

Clinical Manual of
**Cultural
Psychiatry**

SECOND EDITION



Edited by

Russell F. Lim, M.D., M.Ed.

Clinical Manual of Cultural Psychiatry

Second Edition

This page intentionally left blank

Clinical Manual of Cultural Psychiatry

Second Edition

Edited by

Russell F. Lim, M.D., M.Ed.



Washington, DC
London, England

Note: The authors have worked to ensure that all information in this book is accurate at the time of publication and consistent with general psychiatric and medical standards, and that information concerning drug dosages, schedules, and routes of administration is accurate at the time of publication and consistent with standards set by the U.S. Food and Drug Administration and the general medical community. As medical research and practice continue to advance, however, therapeutic standards may change. Moreover, specific situations may require a specific therapeutic response not included in this book. For these reasons and because human and mechanical errors sometimes occur, we recommend that readers follow the advice of physicians directly involved in their care or the care of a member of their family.

Books published by American Psychiatric Publishing (APP) represent the findings, conclusions, and views of the individual authors and do not necessarily represent the policies and opinions of APP or the American Psychiatric Association.

If you would like to buy between 25 and 99 copies of this or any other American Psychiatric Publishing title, you are eligible for a 20% discount; please contact Customer Service at appi@psych.org or 800-368-5777. If you wish to buy 100 or more copies of the same title, please e-mail us at bulksales@psych.org for a price quote.

Copyright © 2015 American Psychiatric Association
ALL RIGHTS RESERVED

Manufactured in the United States of America on acid-free paper

18 17 16 15 14 5 4 3 2 1

Second Edition

Proudly sourced and uploaded by [StormRG]
Kickass Torrents | TPB | ET | h33t

Typeset in Adobe Garamond and Helvetica.

American Psychiatric Publishing

A Division of American Psychiatric Association

1000 Wilson Boulevard

Arlington, VA 22209-3901

www.appi.org

Library of Congress Cataloging-in-Publication Data

Clinical manual of cultural psychiatry / edited by Russell F. Lim.—Second edition.
p. ; cm.

Includes bibliographical references and index.

ISBN 978-1-58562-439-3 (pbk. : alk. paper)

I. Lim, Russell F., 1961— editor.

[DNLM: 1. Mental Disorders—ethnology. 2. Community Psychiatry. 3. Cross-Cultural Comparison. WM 31]

RC454

616.89—dc23

2014012210

British Library Cataloguing in Publication Data

A CIP record is available from the British Library.

Contents

Contributors	xvii
Foreword	xxi
<i>Francis G. Lu, M.D.</i>	
Preface	xxv
Acknowledgments	xxix
Video Guide	xxxi

www.appi.org/Lim

1	Assessment of Culturally Diverse Individuals:	
	Introduction and Foundations	1
	<i>Hendry Ton, M.D., M.S. and Russell F. Lim, M.D., M.Ed.</i>	
	Historical Perspective	3
	Critical Concepts	4
	Outline for Cultural Formulation	6
	Cultural Formulation Interview	7
	Historical Background	8
	Conclusion	36
	References	37
2	Applying the DSM-5 Outline for Cultural	
	Formulation and the Cultural Formulation	
	Interview: A Resident's/Early Career	
	Psychiatrist's Perspective	43
	<i>Angel Caraballo, M.D., Jennifer Robin Lee, M.D., and</i>	
	<i>Russell F. Lim, M.D., M.Ed.</i>	
	Cultural Identity of the Individual	46
	Cultural Concepts of Distress	56

Psychosocial Stressors and Cultural Features of Vulnerability and Resilience	60
Cultural Features of the Relationship Between the Individual and the Clinician.	68
Overall Cultural Assessment	72
References	74

3 Issues in the Assessment and Treatment of African American Patients 77

*Tracee Burroughs-Gardner, M.D., Annelle B. Primm, M.D., M.P.H.,
William B. Lawson, M.D., Ph.D., and Deborah Cohen, M.B.A.*

Historical Context	79
Current Context	81
Applying the Updated DSM-5 Outline for Cultural Formulation.	92
Conclusion	117
References	119

4 Issues in the Assessment and Treatment of Asian American Patients 127

Nang Du, M.D. and Russell F. Lim, M.D., M.Ed.

Overview of the Asian American Population	128
Immigration Patterns	128
Assessment and Therapeutic Techniques: Using the DSM-5 Outline for Cultural Formulation and the Cultural Formulation Interview With Asian Americans	134
Conclusion	174
References	174
Suggested Readings	181

5 Issues in the Assessment and Treatment of Latino Patients 183

Amaro J. Laria, Ph.D. and Roberto Lewis-Fernández, M.D.

Social Demographics and History of U.S. Migration Patterns	184
---	-----

Applying the DSM-5 Outline for Cultural Formulation. . . 196
Overall Cultural Formulation. 235
Conclusion 239
References 241

6 Issues in the Assessment and Treatment of American Indian and Alaska Native Patients . . 251

Candace M. Fleming, Ph.D. and Russell F. Lim, M.D., M.Ed.

Current Status 254
Historical Issues That Relate to Mental Health. 255
Mental Health Needs and Service System Issues 258
Applying the DSM-5 Outline for Cultural Formulation. . . 260
Conclusion 279
References 280

7 Cultural Issues in Women’s Mental Health. . . . 287

*Lisa Andermann, M.Phil., M.D., FRCPC and
Kenneth P. Fung, M.D., M.Sc., FRCPC*

Women’s Mental Health and the Women’s
Movement: A Brief History 288
Epidemiology and Psychopathology. 305
Clinical Assessment 306
Developmental Issues in the Woman’s Life Cycle 307
DSM-5 Outline for Cultural Formulation 321
DSM-5 Cultural Formulation Interview 331
Conclusion 332
Cultural Assessment of Gender:
Summary of Key Clinical Skills. 332
References 334

8 Sexual Orientation: Gay Men, Lesbians, and Bisexuals 339

*Marshall Forstein, M.D., Jason Lambrese, M.D., and
Tauheed Zaman, M.D.*

Disclosure of Sexual Orientation to Providers 343
Epidemiology of Homosexuality 343

Psychiatric Disorders and Suicide in Lesbian, Gay, and Bisexual People.	347
History of Homosexuality	349
Sexual Identity Terminology	358
Cultural Identity of the Individual: Development of a Lesbian, Gay, or Bisexual Identity	359
Common Issues for Lesbian, Gay, or Bisexual People Presenting for Treatment Throughout the Life Cycle	375
Assessment	379
Conclusion	387
References	388

9 **Transgender and Gender Nonconforming Patients 397**

Dan H. Karasic, M.D.

Transgender Identity Formation	399
Transition Care and the WPATH Standards of Care, Version 7	400
Transgender Patients in Health Care Settings	402
Case Discussion: Outline for Cultural Formulation.	405
Conclusion	408
References	409

10 **Religious and Spiritual Assessment. 411**

David M. Gellerman, M.D., Ph.D.

Performing a Spiritual Assessment	413
Using the Outline for Cultural Formulation to Organize the Spiritual Assessment	417
Conclusion	429
References	430

11 Ethnopsychopharmacology 435

David C. Henderson, M.D. and Brenda Vincenzi, M.D.

Introduction to the Pharmacogenetics of	
Drug-Metabolizing Enzymes	437
Ethnic Variation in Medication Response	437
Pharmacogenetics of Drug-Metabolizing Enzymes	442
Cytochrome P450 Enzymes and	
Environmental Factors	454
Importance of Nonpharmacological Factors	459
Conclusion	460
References	462

12 Conclusion: Applying the Updated DSM-5 Outline for Cultural Formulation and Cultural Formulation Interview 469

Russell F. Lim, M.D., M.Ed.

Outline for Cultural Formulation	470
Cultural Formulation Interview	473
Final Thoughts	474
References	475

Appendix 1: DSM-5 Outline for Cultural Formulation, Cultural Formulation Interview, and Supplementary Modules 477

Outline for Cultural Formulation	477
Cultural Formulation Interview (CFI).	479
Cultural Formulation Interview (CFI)—Informant	
Version	487
Supplementary Modules to the Core Cultural	
Formulation Interview (CFI)	493

Appendix 2: DSM-5 Glossary of Cultural Concepts of Distress 519

Ataque de nervios.	519
Dhat syndrome	521

Khyâl cap	522
Kufungisisa	523
Maladi moun	525
Nervios	527
Shenjing shuairuo	528
Susto	530
Taijin kyofusho	532

**Appendix 3: Cultural Formulations of
Case Examples Seen in the Videos. 535**

Russell F. Lim, M.D., M.Ed. and Hendry Ton, M.D., M.S.

Chapter 2: Vietnamese American Case— Mr. Tran	535
Chapter 3: African American Case—Mr. Jones	539
Chapter 4: Asian American Case—Mr. Chen	542
Chapter 5: Latino Case—Mrs. Santiago	546
Chapter 7: White Euro-American Case— Ms. Diamond	549

Bibliography 553

Francis G. Lu, M.D.

Books	553
Journals	561
Web Sites	561

Index. 565

List of Tables

Table 1–1	Essential components of culture	5
Table 1–2	DSM-IV-TR and DSM-5 Outline for Cultural Formulation	8
Table 1–3	Cultural Formulation Interview	10
Table 1–4	Cultural identity	13
Table 1–5	Migration history	15
Table 1–6	Cultural identity: advantages of assessment.	16
Table 1–7	Conflicting explanatory models	21
Table 1–8	Kleinman’s eight questions	23
Table 1–9	Cultural influences on transference and countertransference.	27
Table 1–10	Competency criteria for interpreters	32
Table 2–1	Useful mnemonics for cultural formulation	47
Table 2–2	Culture-bound syndromes (cultural concepts of distress) in Asia	61
Table 2–3	Culture-bound syndromes (cultural concepts of distress) in Latin America.	62
Table 2–4	Culture-bound syndromes (cultural concepts of distress) in industrialized countries	63
Table 2–5	Culture-bound syndromes (cultural concepts of distress) in Africa and the Caribbean	64
Table 2–6	Culture-bound syndromes (cultural concepts of distress) among Native Americans	65
Table 3–1	DSM-IV-TR Outline for Cultural Formulation (OCF) and updated DSM-5 OCF.	94
Table 3–2	Critique of therapist and skills	112
Table 4–1	Major Asian American groups in the 2010 U.S. Census	129
Table 4–2	Cultural concepts of distress	142

Table 4–3	Religious philosophies	144
Table 4–4	Alternative beliefs and healing strategies	148
Table 4–5	Common Asian American beliefs about medications and strategies	156
Table 4–6	Ten tips for psychotherapy with Asian Americans	170
Table 5–1	Educational status, financial status, and employment status of non-Hispanic whites and Hispanics in the United States, 2012	186
Table 6–1	Preparing to see a Native patient	259
Table 6–2	Native American patient's expectations of a non-Native healer	274
Table 6–3	Native American patient's expectations of an indigenous healer	275
Table 6–4	Native American patients' desired characteristics of therapists	276
Table 6–5	Developing trust between Indian and Native patients and their therapists	277
Table 6–6	Building effective therapeutic relationships between Indian and Native patients and therapists	278
Table 6–7	Suggestions for working with Native American patients	279
Table 7–1	Practical guide to culturally competent assessment on gender issues: identifying data/history of present illness and psychiatric history	292
Table 7–2	Practical guide to culturally competent assessment on gender issues: mental status examination	308
Table 7–3	Practical guide to culturally competent assessment on gender issues: assessment of personal history	312
Table 8–1	Where same-sex relationships are legal	357

Table 8–2	Dimensions of sexual, social, and psychological orientation	360
Table 8–3	Cass’s six stages of sexual identity development	365
Table 8–4	Questions from the Cultural Formulation Interview (CFI) and supplementary modules for lesbian, gay, and bisexual patients	384
Table 10–1	Mnemonics for a spiritual assessment	416
Table 11–1	Ethnicity and atypical antipsychotics	443
Table 11–2	Summary: major human cytochrome P450 (CYP450) enzymes and their psychotropic substrates	444
Table 11–3	Cytochrome P450 (CYP450) isoenzymes, inhibitors, and inducers	446
Table 11–4	Cytochrome P450 (CYP450) 2D6 metabolic rates.	448
Table 11–5	Herb–cytochrome P450 (CYP450) drug interactions	458
Table 11–6	Herbal medications and cytochrome P450 (CYP450) enzymes	459
Table 11–7	Five tips for working with ethnic minority patients	461

This page intentionally left blank

List of Figures

Figure 1–1	The therapeutic triad model.	31
Figure 3–1	Use of mental health services by race/ethnicity.	90
Figure 3–2	Non-M.D. service use by race.	91
Figure 11–1	Factors affecting drug metabolism.	436
Figure 11–2	Haloperidol metabolism by route and ethnicity.	440
Figure 11–3	Cytochrome P450 (CYP450) 2D6 poor metabolizers (PM) and slow metabolizers (SM).	449
Figure 11–4	Cytochrome P450 (CYP450) 2D6 ultrarapid metabolizers.	451
Figure 11–5	Cytochrome P450 (CYP450) 2C19 activity and half-life of diazepam in Chinese patients.	454
Figure 11–6	Nifedipine side effects and corn.	456

This page intentionally left blank

Contributors

Lisa Andermann, M.Phil., M.D., FRCPC

Assistant Professor, Equity, Gender and Populations Division, Department of Psychiatry, University of Toronto and Mount Sinai Hospital, Toronto, Ontario, Canada?

Tracee Burroughs-Gardner, M.D.

CEO/Medical Director, Urban Behavioral Associates, Baltimore, Maryland

Angel Caraballo, M.D.

Assistant Clinical Professor of Psychiatry, Columbia University, New York, New York

Deborah Cohen, M.B.A.

Research Project Manager, American Psychiatric Association, Arlington, Virginia

Nang Du, M.D.

Clinical Professor of Psychiatry, University of California, San Francisco, California; Medical Chief, San Mateo North County BHRS Services, Daly City, California

Candace M. Fleming, Ph.D.

Associate Professor and Director of Training, American Indian and Alaska Native Programs, Anschutz Medical Campus, University of Colorado Denver, Aurora, Colorado

Marshall Forstein, M.D.

Associate Professor of Psychiatry, Harvard Medical School; Director, Adult Psychiatry, Residency Training, Cambridge Hospital, Cambridge Health Alliance, Cambridge, Massachusetts

Kenneth P. Fung, M.D., M.Sc., FRCPC

Clinical Director, Asian Initiative in Mental Health, Toronto Western Hospital; Associate Professor, Equity, Gender and Populations Division, Department of Psychiatry, University of Toronto, Toronto, Ontario, Canada

David M. Gellerman, M.D., Ph.D.

Staff Psychiatrist, Sacramento VA Medical Center, Mather, California; Assistant Clinical Professor, Department of Psychiatry, University of California at Davis Medical Center, Sacramento, California

David C. Henderson, M.D.

Associate Professor of Psychiatry, Massachusetts General Hospital, Harvard Medical School; Director, Chester M. Pierce, MD Division of Global Psychiatry and Director, Schizophrenia Clinical and Research Program, Massachusetts General Hospital, Boston, Massachusetts

Dan H. Karasic, M.D.

Health Sciences Clinical Professor of Psychiatry, UCSF, San Francisco, California

Jason Lambrese, M.D.

Adult Psychiatry Resident, Cambridge Hospital; Clinical Fellow in Psychiatry, Department of Psychiatry, Harvard Medical School, Cambridge, Massachusetts

Amaro J. Laria, Ph.D.

Clinical Instructor in Psychology, Department of Psychiatry, Cambridge Health Alliance/Harvard Medical School, Boston, Massachusetts; Founder and Director, Boston Behavioral Medicine, Brookline, Massachusetts

William B. Lawson, M.D., Ph.D.

Professor and Chair, Department of Psychiatry, Howard University College of Medicine, Washington, D.C.

Jennifer Robin Lee, M.D.

Westport, Connecticut

Roberto Lewis-Fernández, M.D.

Professor of Psychiatry, Columbia University Medical Center; Director, New York State Center of Excellence for Cultural Competence, New York State Psychiatric Institute; Director, Hispanic Treatment Program, New York State Psychiatric Institute, New York, New York

Russell F. Lim, M.D., M.Ed.

Health Sciences Clinical Professor, Department of Psychiatry and Behavioral Sciences, University of California Davis School of Medicine, Sacramento, California

Francis G. Lu, M.D.

Luke and Grace Kim Professor in Cultural Psychiatry, Emeritus, Department of Psychiatry and Behavioral Sciences, University of California Davis School of Medicine, Sacramento, California

Annelle B. Primm, M.D., M.P.H.

Director, Department of Minority and National Affairs, and Deputy Medical Director, American Psychiatric Association, Arlington, Virginia

Hendry Ton, M.D., M.S.

Medical Director, Transcultural Wellness Center; Health Sciences Associate Clinical Professor, Department of Psychiatry and Behavioral Sciences, University of California Davis School of Medicine, Sacramento, California

Brenda Vincenzi, M.D.

Schizophrenia Clinical and Research Program, Massachusetts General Hospital, Boston, Massachusetts

Tauheed Zaman, M.D.

Adult Psychiatry Resident, Cambridge Hospital; Clinical Fellow in Psychiatry, Department of Psychiatry, Harvard Medical School, Cambridge, Massachusetts

Disclosure of Interests

The following contributors to this book have indicated a financial interest in or other affiliation with a commercial supporter, a manufacturer of a commercial product, a provider of a commercial service, a nongovernmental organization, and/or a government agency, as listed below:

William B. Lawson, M.D., Ph.D. *Grants:* Merck, Inc.; Otsuka Pharmaceutical Development & Commercialization, Inc. *Speakers bureau:* Reckitt Benckiser

Roberto Lewis-Fernández, M.D. *Grants:* National Institute of Mental Health; Office of Mental Health, State of New York; Columbia University; Eli Lilly & Co.

The following contributors have indicated that they have no financial interests or other affiliations that represent or could appear to represent a competing interest with their contributions to this book:

Lisa Andermann, M.Phil., M.D., FRCPC, Angel Caraballo, M.D., Nang Du, M.D., Marshall Forstein, M.D., Kenneth P. Fung, M.D., M.Sc., FRCPC, David M. Gellerman, M.D., Ph.D., David C. Henderson, M.D., Dan Karasic, M.D., Jason Lambrese, M.D., Amaro J. Laria, Ph.D., Jennifer Robin Lee, M.D., Russell F. Lim, M.D., M.Ed., Francis G. Lu, M.D., Hendry Ton, M.D., M.S., Brenda Vincenzi, M.D., Tauheed Zaman, M.D.

Foreword

The Outline for Cultural Formulation (OCF), first published in DSM-IV in 1994 and reprinted in DSM-IV-TR (American Psychiatric Association 1994, 2000), provided the starting point for the first edition of the *Clinical Manual of Cultural Psychiatry*. That first edition was based on the continuing medical education courses on the OCF directed by Dr. Russell Lim, first given at the American Psychiatric Association Annual Meeting in 1996, which have continued on an annual basis. With the publication of DSM-5 in 2013 (American Psychiatric Association 2013), this second edition is a timely update that incorporates important changes in cultural issues for psychiatric diagnosis, formulation, and treatment planning led by Roberto Lewis-Fernández, M.D., chair of the Cultural Issues Workgroup of the DSM-5 Gender and Cross-Cultural Issues Study Group.

First, as reflected in the new chapters on women's issues; lesbian, gay, and bisexual issues; transgender and gender nonconforming patient issues; and religion and spirituality, this second edition embraces the explicit expansion of the definition of the cultural identity of the individual in the DSM-5 revised OCF that included this new sentence: "Other clinically relevant aspects of identity may include religious affiliation, socioeconomic background, personal and family places of birth and growing up, migrant status, and sexual orientation" (American Psychiatric Association 2013, p. 750). This welcome addition to the definition of the cultural identity of the individual provides important dimensions of cultural identity that should be assessed along with race, ethnicity, language, and migration, which were the focus of the defini-

tion in DSM-IV and DSM-IV-TR, to provide a holistic understanding of the unique cultural identity of the individual seen in the clinical encounter.

The second major revision to the DSM-IV OCF in DSM-5 was the use of the term *cultural conceptualizations of distress* instead of the much narrower term *cultural explanations of illness* to capture a fuller range of patient experiences of illness, now broadened to include cultural syndromes and idioms of distress in addition to cultural explanations of illness. This second edition provides important examples so clinicians can recognize these phenomena and incorporate them correctly in their diagnostic formulation so as to reduce the chance of misdiagnosing these cultural phenomena as signs and symptoms of mental disorders.

Third, this second edition thoroughly discusses the use of the Cultural Formulation Interview (CFI; see Appendix 1), which is entirely new in DSM-5 (American Psychiatric Association 2013, pp. 750–757). This major innovation in DSM-5 provides 16 key questions for clinicians to ask patients to elicit information relevant to the OCF. In addition, there is a second version for clinicians to use with informants. Finally, in the Assessment Measures section of the online DSM-5, there are 12 supplementary modules to probe in greater detail on specific areas discovered by using the CFI. These materials can be accessed at <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Cultural>.

The last (but not least) innovation in the second edition is online access to video vignettes that demonstrate parts of a diagnostic interview aimed at obtaining information for the DSM-5 OCF. James Boehnlein, M.D., Professor of Psychiatry at Oregon Health and Sciences University and past president of the Society for the Study of Psychiatry and Culture, interviews several simulated patients from diverse cultural backgrounds.

One of the joys of academic psychiatry, despite its many challenges, is the opportunity to mentor trainees and to see the arc of their career development. I have been fortunate and grateful to have had this opportunity in my career with the editor of this book, Russell F. Lim, M.D., who was a psychiatry resident I mentored at the University of California, San Francisco, in the early 1990s, when our collaborative teaching began about the OCF. When published in 2006, the first edition of this book provided clinicians, trainees, and faculty the clinical tools to bring culture into the clinical encounter to make more accurate diagnoses and to enhance treatment plans through the use of the OCF

for the four major racial/ethnic minority groups. With this second edition, Dr. Lim and his colleagues have indeed brought the field of cultural assessment in clinical psychiatry to a new level of development commensurate with DSM-5, just 20 years after the publication of the original OCF in DSM-IV.

Francis G. Lu, M.D.

References

- American Psychiatric Association: Appendix I: Outline for cultural formulation and glossary of culture-bound syndromes, in *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition. Washington, DC, American Psychiatric Association, 1994, pp 843–849
- American Psychiatric Association: Appendix I: Outline for cultural formulation and glossary of culture-bound syndromes, in *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000, pp 847–903
- American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition. Washington, DC, American Psychiatric Association, 2013

This page intentionally left blank

Preface

This book began as a continuing medical education (CME) course titled “DSM-IV Cultural Formulation: Diagnosis and Treatment” first given at the American Psychiatric Association’s 149th annual meeting in New York in 1996. Since then, it has been revised, repeated 16 times, presented at 10 Institutes for Psychiatric Services, used as a model for a successful CME program at the UC Davis (UCD) Medical Center, and used as a faculty development course for Department of Psychiatry faculty and staff at UCD and the University of California, San Francisco. It should come as no surprise that the course was the inspiration for this clinical manual. When I first created the course, I wanted to gather experts in the four major nationally recognized ethnic minority groups and have them present cases that would demonstrate particular aspects of working with those groups. I also recruited experts in the areas of cultural competence and ethnopsychopharmacology. I never imagined that I would be running the course 16 years later or that I would be editing a second edition of a book distilling out what we learned after teaching the course more than 25 times.

As I do in the course, I would invite you to see the United States from a different perspective: as an outsider from another country, as my father did when he came to the United States in 1941. Living with my father taught me to understand the differences between his life in China and my life in America. Having the ability to see someone else’s worldview is essential to working with ethnic minority and culturally diverse patients, even if they are from the

South, East, Midwest, or West regions of the United States. We all have our own “cultures,” and the techniques and information contained in this manual will help you to understand all patients better, regardless of their background, nationality, or ethnicity.

With all things, change and innovation are inevitable, and cultural psychiatry is no exception to evolution. In the 8 years since the publication of the first edition, we have seen the publication of the fifth edition of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association 2013), which includes an updated Outline for Cultural Formulation, which we use in our text. A new innovation, the Cultural Formulation Interview, is included in DSM-5, and we have provided its text, an informant module, and its 12 supplementary modules—1) Explanatory Model; 2) Level of Functioning; 3) Social Network; 4) Psychosocial Stressors; 5) Spirituality, Religion, and Moral Traditions; 6) Cultural Identity; 7) Coping and Help-Seeking; 8) Patient-Clinician Relationship; 9) School-Age Children and Adolescents; 10) Older Adults; 11) Immigrants and Refugees; and 12) Caregivers—as appendixes to this text, as well as some guidelines for its use in a psychiatric assessment. In addition, every chapter has been reviewed and updated. I have also added four new chapters: one on religion and spirituality; one on women; and two on lesbian, gay, bisexual, and transgender (LGBT) issues, which were important dimensions of cultural identity not addressed in detail in the first edition. The most important addition is a set of excerpts from simulated interviews to illustrate techniques in the chapters where appropriate.

This book contains an introductory chapter on the background of the updated DSM-5 Outline for Cultural Formulation (OCF) and Cultural Formulation Interview (CFI) and how to apply them to interviewing patients, which is followed by a practical chapter on interviewing tips and techniques for eliciting cultural information.

Following the two introductory chapters, there is one chapter on each of the four federally identified minority groups and four additional new chapters for this edition on women, LGBT individuals, and religion and spirituality. Each chapter details the heterogeneity, as well as the commonalities, of the specific group and offers practical advice and case examples to illustrate the main points. These chapters are supplemented by a review of ethnopsychopharma-

cology and a concluding chapter. All of the chapters have been revised to reflect changes in the field since 2005, the year of completion of the first edition.

I hope that this manual will be useful to medical students, psychiatry residents, psychiatrists, psychologists, psychology graduate students, trainees in social work and counseling, social workers, case managers, and other mental health practitioners when they begin the evaluation of patients identifying themselves as belonging to diverse minority groups. The chapters are meant to be an introduction to working with these groups and are not intended to serve as a substitute for cultural consultation with a person familiar with a specific group, nor are they meant to be stereotypical. I have always believed that I could trust my audience to use this type of information as a reference point from which to ask the question “Is what I am seeing in this patient normal behavior in his or her culture?” If readers feel that they have learned *when* to ask this question, then their understanding of the interaction of culture and mental illness will have begun, and this book will have served its purpose.

Russell F. Lim, M.D., M.Ed.

Reference

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Washington, DC, American Psychiatric Association, 2013

This page intentionally left blank

Acknowledgments

The second edition of this book would not have been possible without the contributions of many people. First and foremost is my mentor and friend, Francis Lu, who suggested that I put the course together in 1995 and has been one of my course speakers since the beginning. Elizabeth Kramer has been a friend, supporter, and editor without whose help I could not have completed the first edition. Many thanks to Michele Clark, Kenneth Gee, N. Charles Ndlela, Candace Fleming, Jessie Sanchez, Maria Oquendo, Silvia Olarte, Renato Alarcon, David Henderson, Michael Smith, Linda Naluhu, and Frank Brown, who have all served as faculty in my course, and many of whom were presenters as well and authors of chapters in this book. I would like to thank my volunteers for the videotaped scenes: JoEllen Branin-Rodriquez, Jevon Johnson, Debra Kahn, Hong Shen, and Roger Quan, who portrayed the patients; James Boehnlein and Hendry Ton for demonstrating their use of cultural assessment techniques; and Daniel Murphy and Sal Gallagher for their excellent work in videotaping the interviews. I thank my former supervisors in my residency program at the University of California, San Francisco, especially Francis Lu, Nang Du, and Frank Johnson, who opened up the world of cultural psychiatry for me and who taught me most of what I know about psychiatry. In addition, I would like to thank my wife, Sally, and my two children, Jackie and James, for putting up with me typing at odd hours of the night and morning and weekends. I also would like to acknowledge the support of my chair and editor-in-chief of American Psychiatric Publishing, Robert Hales. Finally, I thank my greatest teachers: my course attendees, residents, and students, who have asked the important questions that have caused me to revise

my course and other presentations in helpful ways and continue to show us that the need to teach these skills to psychiatrists and trainees remains.

Video Guide

The second edition of this book includes what we believe is a useful and practical innovation: access to videotaped examples with simulated patients to illustrate the practical application of the DSM-5 Outline for Cultural Formulation (OCF) and Cultural Formulation Interview (CFI). These videos provide the reader an experience similar to observing seasoned clinicians doing evaluations of patients, and they have the advantage of being available at any time, without requiring the patient, clinician, or clinic to be present while reading the text.



Video Illustration: Video cues provided in the text identify the vignettes by title and run time.

The videos can be viewed online by navigating to www.appi.org/Lim and using the embedded video player. The videos are optimized for most current operating systems, including mobile operating systems iOS 5.1 and Android 4.1 and higher.

Note. All of the patients who appear in the videos that accompany this book are actors, not actual patients, and the clinical cases portrayed are fictional. Any resemblance to real persons is purely coincidental.

Video Vignettes

Chapter 1. Assessment of Culturally Diverse Individuals: Introduction and Foundations

- 1–1 Introduction to cultural formulation (1:37)
- 2–2 Treatment negotiation—Asian American (5:04)
- 3–3 Role of the community (5:09)
- 5–1 Cultural concepts of distress—*ataque de nervios* (3:06)
- 6–1 Cultural identity and religion (3:55)
- 6–2 Transference and countertransference (5:18)

Chapter 2. Applying the DSM-5 Outline for Cultural Formulation and the Cultural Formulation Interview: A Resident's/Early Career Psychiatrist's Perspective

- 5–1 Cultural concepts of distress—*ataque de nervios* (3:06)

Chapter 3. Issues in the Assessment and Treatment of African American Patients

- 3–1 Cultural identity—African American (4:13)
- 3–2 Spiritual assessment (2:37)
- 3–3 Role of the community (5:09)
- 3–4 Treatment negotiation—African American (5:51)
- 3–5 Cultural identity of the individual (3:48)
- 3–6 Mixed therapist-patient dyad (3:52)

Chapter 4. Issues in the Assessment and Treatment of Asian American Patients

- 2–1 Eliciting an explanatory model (3:14)
- 2–2 Treatment negotiation—Asian American (5:04)
- 4–1 Migration history and cultural identity (3:42)
- 4–2 Cultural concepts of distress—shame (8:21)
- 4–3 Cultural adjustment (4:19)

Chapter 5. Issues in the Assessment and Treatment of Latino Patients

- 5-1 Cultural concepts of distress—*ataque de nervios* (3:06)
- 5-2 Gender values and community (3:21)
- 5-3 Family structure (4:27)

Chapter 6. Issues in the Assessment and Treatment of American Indian and Alaska Native Patients

- 5-1 Cultural concepts of distress—*ataque de nervios* (3:06)

Chapter 7. Cultural Issues in Women's Mental Health

- 6-1 Cultural identity and religion (3:55)
- 6-2 Transference and countertransference (5:18)
- 6-3 Cultural formulation (6:20)

Chapter 10. Religious and Spiritual Assessment

- 3-2 Spiritual assessment (2:37)
- 6-1 Cultural identity and religion (3:55)
- 6-2 Transference and countertransference (5:18)

This page intentionally left blank

Assessment of Culturally Diverse Individuals

Introduction and Foundations

Hendry Ton, M.D., M.S.

Russell F. Lim, M.D., M.Ed.

The United States is becoming increasingly diverse. The non-Hispanic white population constitutes 63% of the total population, and minority groups are rapidly growing. Over the past decade, for example, the Hispanic and Asian American populations grew by 43%, whereas the white population, numbered

Portions of this chapter are based on Lu FG, Lim RF, Mezzich JE: "Issues in the Assessment and Diagnosis of Culturally Diverse Individuals," in *American Psychiatric Press Review of Psychiatry*, Vol. 14. Edited by Oldham J, Riba M. Washington, DC, American Psychiatric Press, 1995, pp. 477–510. Copyright 1995, American Psychiatric Press. Used with permission.

at about 196 million, had the smallest degree of growth at 5.7%. Currently, more than 50 million Hispanics and nearly 35 million African Americans live in the United States. Ten years ago, the populations of Hispanics and African Americans were nearly equal, at 35 million. Today, Asian Americans and Pacific Islanders number about 15 million, whereas the American Indian and Alaska Native communities are nearly 3 million in size (U.S. Census Bureau 2011). By 2050, non-Hispanic whites will make up less than 50% of the U.S. population (U.S. Census Bureau 2008). Ethnic variations reflect only a fraction of the diversity in our society, however. There is also tremendous diversity in gender, sexual orientation, age, occupation, socioeconomic status, and religious and spiritual affiliations. In addition, technological advances in communication and transportation have enabled the development of a global community composed of multitudes of languages, customs, and beliefs and the blending of these factors in multicultural individuals.

Our society will undoubtedly continue to be enriched by the ideas, perspectives, and contributions of the many groups of which it is composed. Mental health providers, however, face the particularly challenging task of providing culturally competent care to an increasingly diverse community. In 2001, the Office of the Surgeon General released a detailed supplement to the report *Mental Health: A Report of the Surgeon General* titled *Mental Health: Culture, Race, and Ethnicity* about the growing crisis of inadequate mental health services for U.S. ethnic minorities (U.S. Department of Health and Human Services 2001a). The report identifies several disparities in the mental health care of racial and ethnic minorities compared with white patients: minorities 1) have less access to, and availability of, mental health services; 2) are less likely to receive needed mental health services; 3) often receive lower-quality mental health care when in treatment; and 4) are underrepresented in mental health research. Disparities extend beyond ethnic minorities. Women, for example, have significantly higher rates of posttraumatic stress disorder and mood disorders. They are also more likely to have three or more comorbid disorders (Kessler et al. 1994, 1995, 1998). Yet research in areas of women's mental health outside of the relationship between reproductive functioning and mental health has been neglected (Dennerstein et al. 1997). Lesbian, gay, bisexual, and transgender (LGBT) patients likewise face significant disparities. Almost 8% of LGB and 27% of transgender patients report being refused needed health care (Lambda Legal 2010). Although these statistics are alarming, rec-

ognition of the unmet needs of diverse communities will enable mental health providers and policy makers to take steps to seriously address and remedy these issues. Finally, religious and spiritual beliefs have been found to have both positive and negative effects (Koenig and Larson 2001). Studies showed that religious college students seemed to have more anxiety than did nonreligious college students. Teenage mothers who were religious had more depression than did those without religion, although a cohort study found that two-thirds of individuals with depression and strong religious beliefs did better than those without strong religious beliefs, and other studies showed that subjects with religious beliefs scored higher on the hope and optimism scale. These studies suggested that religion is an important dimension to assess during a psychiatric assessment because an important support or stressor might be uncovered.

The purpose of this manual is to help clinicians take steps to address these important issues by teaching the reader the skills necessary for culturally appropriate assessment and, in some cases, demonstrating those skills with a simulated patient via videos available at www.appi.org/Lim. In this chapter, we highlight the principles of cultural psychiatry used in the assessment and treatment of psychiatric conditions, and in Chapter 2, “Applying the DSM-5 Outline for Cultural Formulation and the Cultural Formulation Interview,” Caraballo and colleagues offer some practical guidelines on how to gather the proper information during the psychiatric intake assessment.

Historical Perspective

The first published account of cultural psychiatry dates back to more than 100 years ago, when unusual clinical syndromes were seen in non-Western countries and were described using Western universalistic interpretations of these findings (Group for the Advancement of Psychiatry Committee on Cultural Psychiatry 2002). This ethnocentric approach did little to incorporate cultural evaluation into mainstream psychiatry because it tended to limit the focus of cultural inquiry to exotic or isolated locations and cultural groups. By the latter half of the twentieth century, modern psychiatry had come under criticism by sociologists and cultural anthropologists who were concerned with the cultural relativity of mental disorders, believing that mental illness is socially defined (Kleinman 1988). Most psychiatrists who contributed to DSM-IV (American Psychiatric Association 1994a) held the perspective of

scientific universalism that “patients are more alike than different” and were resistant to seeing disorders through another’s cultural lenses.

Psychiatry’s initial response was to reaffirm its scientific foundations and to view culture as a set of confounding variables that distorted how the real psychiatric disorders manifested (Fàbrega 2001). However, interest in investigating the interplay between psychiatric disorders and sociocultural factors continued to develop, culminating in the universal acceptance of Engel’s biopsychosocial approach in the 1980s (Group for the Advancement of Psychiatry Committee on Cultural Psychiatry 2002). Subsequently, there have been significant advances in our understanding of the impact of culture on psychopharmacology and psychotherapy, on the application of treatment to ethnic minorities, and on the development of culturally appropriate mental health services. An example of this can be seen in the Outline for Cultural Formulation (OCF) and the Glossary of Culture-Bound Syndromes in DSM-IV-TR (American Psychiatric Association 2000) and the updated OCF and Glossary of Cultural Concepts of Distress in DSM-5, as well as the DSM-5 Cultural Formulation Interview (CFI; American Psychiatric Association 2013). Another example is a pharmacogenetic assay for gene coding for the cytochrome P450 enzymes that metabolize psychiatric medications, recently released by AssureRx and other companies, which allows clinicians to estimate their patients’ metabolism of medications compared with the majority group (see Chapter 11, “Ethnopsychopharmacology”). The consideration of cultural factors in the evaluation of patients with mental illness will result in improved access to care, an increased understanding of patients’ illness experiences, more accurate diagnosis, and, ultimately, better treatment.

Critical Concepts

Culture has been defined in many different ways, an indication that even the most comprehensive definitions cannot encompass all of its attributed meanings. In this section, we attempt to define *culture* in terms that are user-friendly and relevant to the mental health clinician. *Culture* can be defined as a set of meanings, norms, beliefs, and values shared by a group of people; it is dynamic and evolves over time and with each generation (Matsumoto 1996). Gaw (2001) described six essential features of culture (see Table 1–1). Culture is learned and therefore can be taught and reproduced. The term *culture* refers

Table 1–1. Essential components of culture

Culture is learned.

Culture refers to a system of meanings.

Culture acts as a shaping template.

Culture is taught and reproduced.

Culture exists in a constant state of change.

Culture includes patterns of both subjective and objective components of human behavior.

Source. Adapted from Gaw 2001.

to a system of meanings in which words, behaviors, events, and symbols have attached meanings that are agreed on by members within the cultural group. Hence, culture shapes how individuals make sense of the social and natural world. Culture also encompasses a body of learned behaviors and perspectives that serves as a template to shape and orient future behaviors and perspectives from generation to generation and as novel situations emerge. Finally, culture includes both the subjective components of human behavior (the shared ideas and meanings that exist within the minds of individuals within a group) and the objective components (the observable behaviors and interactions of these individuals).

Culture shapes how and what symptoms are expressed (Mezzich et al. 2000; Rogler 1993), and it influences the meaning that one attributes to symptoms. Culture also determines what a society regards as appropriate or inappropriate behavior. In other words, culture influences the conceptualization and rationale of psychiatric diagnostic categories and groupings. In addition, culture provides the matrix for the clinician-patient exchange. Alarcón et al. (1999) stated that culture can operate as both a pathogenic and a pathoplastic agent. The association of war with posttraumatic stress disorder is one example of how cultural events can cause or contribute to psychopathology (Du and Lu 1997; Kirmayer 2001). Likewise, culture can exert a protective influence on mental health. Some evidence indicates, for example, that the extended family systems in non-Western cultures can mitigate the effects of schizophrenia (Kulhara and Chakrabarti 2001). Traditional healing approaches and spiritual or religious interventions can also provide meaningful

benefits to patients (Kinzie 2000; Lee 1997a; Lukoff et al. 1995; Muskin 2000; Pulchaski 2006).

The terms *culture*, *ethnicity*, and *race* are often used interchangeably, but it is important to highlight the distinctions among the three concepts. Like culture, ethnicity and race have been defined in many ways. *Ethnicity* can be used to refer to an individual's sense of belonging to a group of people who have a common set of beliefs and customs (culture) and who share a common history and origin. In some cases, ethnicity is nationality, geographic location, and religious beliefs; sometimes it can go beyond borders, such as is seen in ethnic minorities in nonhost countries. Examples of ethnicity include Vietnamese American, Filipino-Chinese, Russian Jewish, and Ethiopian. *Race* is often used to refer to a group of people who share common biological similarities (Lu et al. 1995). Thus, individuals are grouped together according to physical appearance, such as skin color, with little attention paid to actual biological or genetic determinants, leading to much disagreement about what the biological similarities attributed to a particular race are. In much of U.S. history, the use of race has had the effect of furthering racial prejudices and inequalities. In psychiatry, race is a powerful influencing factor in the clinician-patient dyad. African Americans, for example, often have been misdiagnosed with schizophrenia (Adebimpe 1981), likely because of differences in interactional styles and values and the interpretation of these factors according to mainstream norms rather than because of any specific biological predisposition to psychosis (U.S. Department of Health and Human Services 2001a). It is important to note, however, that although biological definitions of ethnicity and race may have problems and be difficult to validate, the concepts as they are described here do not exclude biological similarities between members of an ethnic group. Each individual's culture may encompass a sense of ethnicity and perhaps race, but many other affiliations, such as occupation, age, gender, sexual orientation, spirituality, and religion, contribute to his or her overall cultural identity.

Outline for Cultural Formulation

The publication of DSM-IV in 1994; its subsequent text revision, DSM-IV-TR; and its update, DSM-5, represented a turning point in the application of

cultural psychiatry principles by introducing the OCF (American Psychiatric Association 1994b). The OCF gives clinicians a framework for assessing the impact of culture on psychiatric illness. Because culture plays such a crucial role in all aspects of mental health and illness, it is important to incorporate the cultural assessment as an essential part of the diagnostic interview and treatment planning. The astute clinician strives to gain knowledge about the cultural groups to which his or her patients belong. The complexity of the interplay between culture and illness can make this process potentially overwhelming. Factual knowledge about cultural groups is essential but can have limited utility without a conceptual framework to organize and to make sense of the information. Furthermore, the clinician will encounter many patients who are affiliated with one or more cultural groups, of which he or she may have inadequate knowledge. In these instances, an organizing framework is helpful to guide the clinician to areas of potentially important inquiry, especially when asking for a cultural consultation from a member of the patient's cultural group.

Cultural Formulation Interview

A further refinement of the DSM-5 OCF, the CFI, can be found in DSM-5 (American Psychiatric Association 2013). The CFI is an evolutionary step from the OCF. It operationalizes the OCF into an interview format, with modules on particular areas to be added if relevant. It is a more *process-oriented* approach to cultural assessment because it has sample questions that can be added to any psychiatric interview. The CFI gives mental health professionals a starting point from which to conduct a cultural evaluation and answers the question "How do I do this, and how is it different from a standard interview?" It consists of 16 questions, an informant module, and 12 supplementary modules, including 1) Explanatory Model; 2) Level of Functioning; 3) Social Network; 4) Psychosocial Stressors; 5) Spirituality, Religion, and Moral Traditions; 6) Cultural Identity; 7) Coping and Help-Seeking; 8) Patient-Clinician Relationship; 9) School-Age Children and Adolescents; 10) Older Adults; 11) Immigrants and Refugees; and 12) Caregivers (see Appendix 1, "DSM-5 Outline for Cultural Formulation, Cultural Formulation Interview, and Supplementary Modules").

Historical Background

In 1990, the Task Force on DSM-IV, chaired by Allen Frances, M.D., convened for the planning of DSM-IV. For the first time, serious consideration was given to incorporating cultural factors into the evaluation and diagnosis of mental disorders (Mezzich et al. 2001). The task force formed the Culture and Diagnosis Work Group, composed of many of the leading clinical and scholarly experts on culture in the mental health disciplines, to address culture or the lack thereof in DSM-IV. The OCF was one of the work group's later contributions. The OCF is based on an extensive review of the literature that identified five major areas in which culture has major influences on mental health and illness (see Table 1–2). Field trials further substantiated its usefulness (Mezzich et al. 2001). Although a significant portion of the work group's recommendations was omitted in the final text of DSM-IV, the OCF was included in Appendix I along with the Glossary of Culture-Bound Syndromes. These guidelines quickly became regarded as a crucial innovation in cultural psychiatry. The CFI, developed by the Cultural Psychiatry Committee of the Group for the Advancement of Psychiatry and introduced in DSM-5, should prove to be the next crucial innovation in cultural psychiatry (see Table 1–3).

Table 1–2. DSM-IV-TR and DSM-5 Outline for Cultural Formulation

DSM-IV-TR	DSM-5
Cultural identity of the individual	Cultural identity of the individual
Cultural explanations of the individual's illness	Cultural concepts of distress
Cultural factors related to psychosocial environment and levels of functioning	Psychosocial stressors and cultural features of vulnerability and resilience
Cultural elements of the relationship between the individual and the clinician	Cultural features of the relationship between the individual and the clinician
Overall cultural assessment for diagnosis and care	Overall cultural assessment

Source. American Psychiatric Association 2000, 2013.

In the following section, the five major areas of the DSM-5 OCF are discussed via a case example. The patient's history is presented first, followed by a discussion of each of these five major areas. Drawn from an actual cultural evaluation, this case is meant to illustrate the practical application of the cultural formulation in clinical practice.

Case 1

Ms. W., a 30-year-old Mandarin/English-speaking woman from Hong Kong, was hospitalized after jumping off a multistory building. She had immigrated to the United States 6 months earlier with her husband to work at an industrial company. She left her 7-year-old daughter in Hong Kong because she felt that she was unable to care for her while she worked. Ms. W. reported feeling depressed since moving because of isolation and work stress. She also was unhappy about her relationship with her husband, who remained distant despite numerous overtures on her part to become more intimate. Her husband reported that their relationship was "good" but that she was overly dependent on him. Ms. W. found work very competitive, which she attributed to downsizing and discrimination against non-U.S. citizens.

One month prior to her hospitalization, she became increasingly worried about the safety of her daughter, although she recognized that the worries were unfounded. Several days prior to her hospitalization, Ms. W. lost her job. Her husband encouraged her to return to Hong Kong for a break and visit with family. During a layover on her way to Hong Kong, she encountered ticketing difficulties. She reportedly became overwhelmed and jumped off a multistory building. She later reported that this was because of the shame and stress of losing her job. Ms. W. was interviewed with a Mandarin-speaking interpreter.

Prior to reading the following discussion of the DSM-5 OCF, the reader should view Video 1–1, an introduction to the DSM-IV-TR OCF, in which an experienced cultural psychiatrist, Dr. James Boehnlein of Oregon Health Sciences University, explains his approach in using the DSM-IV-TR OCF.



Video Illustration 1–1: Introduction to cultural formulation (1:37)

Cultural Identity of the Individual

Cultural identity can be understood as a multifaceted core set of identities that contribute to how an individual understands himself or herself and the envi-

Table 1–3. Cultural Formulation Interview

Items in italics refer to the supplementary modules, highlighting the nonlinear process of the typical psychiatric assessment interview and demonstrating the branching process usually observed.

Cultural definition of the problem: *Explanatory Model, Level of Functioning*

1. What brings you here today?
2. Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them?
3. What troubles you most about your problem?

Causes: *Explanatory Model, Social Network, Older Adults*

4. Why do you think this is happening to you?
5. What do others in your family, your friends, or others in your community think is causing your [PROBLEM]?

Stressors and supports: *Social Network; Caregivers; Psychosocial Stressors; Spirituality, Religion, and Moral Traditions; Immigrants and Refugees; Cultural Identity; Older Adults; Coping and Help-Seeking*

6. Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others?
7. Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with money, or family problems?

Role of cultural identity: *Cultural Identity; Psychosocial Stressors; Spirituality, Religion, and Moral Traditions; Immigrants and Refugees; Older Adults; School-Age Children and Adolescents*

8. For you, what are the most important aspects of your background or identity?
9. Are there any aspects of your background or identity that make a difference to your [PROBLEM]?
10. Are there any aspects of your background or identity that are causing other concerns or difficulties for you?

Table 1–3. Cultural Formulation Interview (*continued*)

Self-coping: *Coping and Help-Seeking; Spirituality, Religion, and Moral Traditions; Older Adults; Caregivers; Psychosocial Stressors*

11. Sometimes people have various ways of dealing with problems like [PROBLEM]. What have you done on your own to cope with your [PROBLEM]?

Past help seeking: *Coping and Help-Seeking; Spirituality, Religion, and Moral Traditions; Older Adults; Caregivers; Psychosocial Stressors; Immigrants and Refugees; Social Network; Clinician-Patient Relationship*

12. Often, people look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have you sought for your [PROBLEM]?

Barriers: *Coping and Help-Seeking; Spirituality, Religion, and Moral Traditions; Older Adults; Psychosocial Stressors; Immigrants and Refugees; Social Network; Clinician-Patient Relationship*

13. Has anything prevented you from getting the help you need?

Preferences: *Social Network; Caregivers; Spirituality, Religion, and Moral Traditions; Older Adults; Coping and Help-Seeking*

14. What kinds of help do you think would be most useful to you at this time for your [PROBLEM]?
15. Are there other kinds of help that your family, friends, or other people have suggested would be helpful for you now?

Clinician-patient relationship: *Clinician-Patient Relationship, Older Adults*

16. Have you been concerned about this and is there anything that we can do to provide you with the care you need?

Source. Adapted from American Psychiatric Association 2013.

ronment. Ethnic identity is often a crucial facet of many individuals' overall cultural identity, but other identifications, such as sexual orientation, gender, and socioeconomic status, contribute to it as well. The greater the amount of detail that a clinician is able to ascertain about the individual's cultural identity, the better understanding he or she will have about the individual's per-

spective on health, wellness, illness, and his or her mental health treatment. Moreover, the clinician will more readily anticipate issues around cultural identity conflicts that may arise during the course of evaluation and treatment. Table 1–4 highlights the most common aspects of cultural identity.

A culturally competent clinician develops a set of skills that facilitate an understanding of cultural issues. For example, the clinician needs to be able to elicit the self-defined cultural identity from the patient. Another important aspect of cultural identity is the objective versus subjective dimensions of identity definition. In this respect, it is important to note the distinction between the terms *identity* and *identification*, the latter term referring to a subjective identification with a reference group and the former to a more solidly internalized individual core identity (Phinney 1995). Both play significant roles in one's cultural identity.

Another relevant conceptual distinction, which is often obscured, is that between *culture* and *ethnicity*. These terms tend to be used interchangeably without much definitional clarity. *Ethnicity* typically refers to one's roots, ancestry, and heritage, whereas the concept of *culture* captures more active elements, such as values, understandings, behaviors, and practices. On the basis of this conceptual distinction, it would seem appropriate to claim a Latino ethnic identity based solely on Hispanic roots and heritage, whereas claiming a Latino cultural identity would necessitate participation in, for example, values and behaviors that have been shaped by Latino culture. U.S. mainstream society is heavily influenced by Euro-American Protestant culture, which places a high value on independence, autonomy, and self-sufficiency, perhaps best reflected in the pioneer image of self-reliance and "rugged individualism" (Hsu 1983).

In considering cultural identities, the clinician needs to remember that these identities emerge in particular social contexts and, as such, are fluid, multiple, and changing. Rather than viewing them as fixed traits of individuals or groups, the clinician is advised to regard them as *contextualized identities*. New identities that did not formerly exist for a person may develop in response to migration. For example, a Latino immigrant may adopt a new *ethnic minority* identity after residing in the United States for several years, despite perhaps never having encountered that term in his or her country of origin. An immigrant woman from the Dominican Republic may have been familiar with the terms *Hispana* or *Latina* before migrating to the United States yet

Table 1–4. Cultural identity

Ethnicity
Race
Country of origin
Language
Gender
Age
Marital status
Sexual orientation
Religious/spiritual beliefs
Socioeconomic status
Education
Other identified groups
Migration history
Level of acculturation
Degree of affiliation with above

Source. Adapted from Lu et al. 1995.

come to experience these cultural descriptors as more relevant self-identifiers in the new sociocultural milieu. Similarly, old labels may lose salience, so that a Mexican *chilango* (native of Mexico City) may gradually become more strongly identified as Mexican or Latino the longer he resides in the United States, only to find himself readopting that previous identity label on traveling back to Mexico. In a sense, one may think of identities as having varying degrees of latency or manifest activation according to different situational and contextual factors. Of course, this process of contextual activation of identities is not unique to Latino cultures.

Ideally, the clinician should encourage the patients themselves to describe the aspects of identity that are important to them. A good way of opening the subject is to ask patients about their ethnicity, where they are from, or the origin of their name. In reviewing their answers, the clinician should also note

the degree of affiliation or involvement, negative or positive, that the patient has for each identity because this may highlight areas that strongly influence clinical care. The number of foreign-born residents in the United States was estimated to be almost 37 million in 2010, up from 30 million in 2000 (U.S. Census Bureau 2004, 2011). Therefore, it is important to ask ethnic minority patients where they were born. Ascertaining a migration history is often crucial (Lee 1990) (see Table 1–5). Elements of the migration history that should be obtained include the reason for migration, time spent in transit, and losses and trauma associated with migration, as well as traumatic events before, during, and after migration. The latter factors are particularly important to assess in Southeast Asians and Eastern Europeans, whose migration history is often in the context of violence and war. Care also must be taken to explore the patient's level of acculturation, which includes the patient's prior experience with racism and the degree to which he or she uses mainstream social-cultural resources (e.g., mainstream supermarkets, social networks). The evaluation of the cultural identity helps to clarify several clinical issues. Table 1–6 illustrates some of these advantages.

The prevailing view of acculturation encourages examination of the process on several levels (Escobar and Vega 2000). Is the process one in which the individual is actively or passively involved? Does the push for acculturation come from external sources or from within the individual? Is it a solitary endeavor, or do others participate with the individual? Is the process constant or intermittent? Is it subtle, dramatic, or somewhere in between? What are the individual's attitudes about acculturation in general and specifically about an episode of acculturation? What vision does the individual hold about where the new mix of cultural elements will take him or her? Berry (1997) explained a useful way of describing one's relationship to one's acquired culture (as opposed to one's inherited culture). The individuals who do not adopt the host country customs are described as *separated*, whereas those who fully accept them are known as *assimilated*. Individuals who successfully incorporate both acquired and inherited cultures are *integrated* or *bicultural*, and those who reject both are *marginalized* or *deculturalized*.

Although many rating scales are available, they have limited utility in a clinical context (Tsai et al. 2000). *Acculturation* can be defined as “the process of cultural exchange by which immigrants modify their attributes, beliefs, cultural norms, values, or behaviors as a result of interaction with a different cul-

Table 1–5. Migration history

Premigration history

Country of origin, family, education, socioeconomic status, community and family support, political issues, war, trauma

Experience of migration

Migrant versus refugee: Why did they leave? Who was left behind? Who paid for their trip?

Means of escape, trauma

Degree of loss

Loss of family members, relatives, and friends

Material losses: business, careers, properties

Loss of cultural milieu; community, religious, and spiritual support

Traumatic experience

Physical: torture, rape, starvation, imprisonment

Psychological: rage, depression, guilt, grief, posttraumatic stress disorder

Work and financial history

Original line of work, current occupation, socioeconomic status

Support systems

Community support, religion, family

Medical history

Beliefs in herbal medicine, somatic complaints

Family's concept of illness

What do family members think the problem is? Its cause? What do they do for help? What result is expected?

Level of acculturation

First or second generation

Effect on development

Level of adjustment, assessment of developmental tasks

Source. Adapted from Lee 1990.

Table 1–6. Cultural identity: advantages of assessment

Identify potential areas of strengths and supports that may enhance treatment planning or vulnerabilities that may impede treatment success.

Identify areas of cultural conflict that may need to be addressed. These conflicts can be between the various aspects of identity (e.g., parent vs. worker) or between traditional and mainstream expectations for a particular aspect (e.g., traditional parenting role vs. mainstream parenting role).

By trying to understand who the patient is, the clinician becomes more informed about the patient’s perspective on his or her illness and treatment.

Assist in building rapport because the clinician is attempting to understand the individual as a “whole person” rather than an ill person.

ture” (Heilemann et al. 2000, p. 118). To assess acculturation, patients should be asked whether they follow cultural traditions, what social affiliations they have, what food and dress are preferred, what language they use, what their group identity and generation are, and what their attitudes are toward acculturation. A useful proxy for level of acculturation would be place of birth; age at arrival in the United States; years residing in the United States; and primary language use, including a measure of the proficiency of the second language (Escobar and Vega 2000). In the case of Ms. W. discussed earlier (see Case 1), we could have asked her the following questions (Tsai et al. 2000):

- Do you want to establish good relations with the host culture? Do you want to maintain good relationships with your culture of origin?
- Do you like to spend time with English-speaking people or Chinese-speaking people?
- Can you read, write, and speak Chinese?
- Do you watch Chinese television or movies or listen to Chinese music?
- Which holidays do you celebrate?

Case 2 (Video 6)

Ms. Diamond is a 38-year-old single Jewish American woman from Trumbull, Connecticut, who is living in Manhattan and working as a legal secretary. She came in for treatment of depression that she has had for many years, stating that she is depressed and not happy. She reports chronic unhappiness, starting

from her teenage years, with poor self-esteem and body image. Ms. Diamond also has problems with fatigue and insomnia, falling asleep at 2:00 A.M. and getting only 2–3 hours of sleep per night. She finds her work “annoying,” sees extra work as an imposition on her time, and calls in sick at least once a month. She does not take vacations anymore because they are “too much of a hassle.” She has been in treatment for many years with four or five different therapists, including group therapy, at ages 16, 20, and 25 but remains irritable, sad, guilty, and lonely. Her last therapist was a Jewish woman, who understood her well but retired abruptly, according to the patient, after 3 years of treatment, and she is looking for a new therapist.

Note that in the interview with Dr. Boehnlein and Ms. Diamond, her replies indicate a strong affiliation with her Jewish cultural identity. For example, she states (not shown) that she used JDate, an online dating service for Jewish men and women. In Video 6–1, Dr. Boehnlein asks her if she went to Hebrew school. She tells him that her grandmother was a Holocaust survivor and her mother was involved in Jewish organizations. As a follow-up, Dr. Boehnlein could have asked her if she still goes to temple.



Video Illustration 6–1: Cultural identity and religion (3:55)

A person’s sexual orientation may not be readily discernible by appearance or dress, and a clinician can miss an important aspect of the patient’s identity by assuming that he or she belongs to the majority culture. For example, we may ask a patient if he or she is in a relationship and assume that the partner is male if the patient is female. We need to ask directly the patient’s sexual orientation and/or gender identity (see Chapter 8, “Sexual Orientation: Gay Men, Lesbians, and Bisexuals,” and Chapter 9, “Transgender and Gender Nonconforming Patients”). We can also use CFI supplementary module 6, “Cultural Identity,” questions 26–32:

Gender Identity

26. Do you feel that your [GENDER] has influenced your [PROBLEM] or your health more generally?
27. Do you feel that your [GENDER] has influenced your ability to get the kind of health care you need?

28. Do you feel that health care providers have certain assumptions or attitudes about you or your [PROBLEM] because of your [GENDER]?

Sexual Orientation

29. How would you describe your sexual orientation (e.g., heterosexual, gay, lesbian, bisexual, queer, pansexual, asexual)?
30. Do you feel that your sexual orientation has influenced your [PROBLEM] or your health more generally?
31. Do you feel that your sexual orientation influences your ability to get the kind of health care you need for your [PROBLEM]?
32. Do you feel that health care providers have assumptions or attitudes about you or your [PROBLEM] that are related to your sexual orientation?

In a similar way, we may assume that Latinos and Filipinos are Catholic, when in fact they may be Protestant, or that Caucasians are Protestants, Asians are Buddhists, and Arabs are Muslim, all stereotypes if not checked out with the patient. If a patient volunteers some information, such as “I pray to God for healing,” it would be appropriate to ask the patient what faith he or she practices. In the absence of such information, the clinician should inquire if the patient is religious. See Video 6–1: Dr. Boehnlein asks Ms. Diamond about suicide, to which she replies, “That’s way against my religion.” Note how he takes the opportunity to assess her religious identity (see Chapter 10, “Religious and Spiritual Assessment”).

The CFI can be used to assess cultural identity with core CFI questions 6–10 and supplementary module 6, “Cultural Identity,” which contains 34 questions on cultural identity, organized by 1) national, ethnic, racial background; 2) language; 3) migration; 4) spirituality, religion, and moral traditions; 5) gender identity; and 6) sexual orientation identity, such as question 4: “In terms of your background, how do you usually describe yourself to people outside your community? Sometimes people describe themselves somewhat differently to members of their own community. How do you describe yourself to them?” (see Appendix 1).

The following case example illustrates how inquiry into a patient’s cultural identity can enhance clinician understanding of the patient’s problems.

Case 1 (continued)

When asked what she wanted most, Ms. W. responded, “All I want is to be with my daughter and husband and to have a good job.” Note that she clearly struggles between conflicting roles—her identity as a “working woman” is clearly important to her, in addition to her role as a wife and mother. In China’s post–Cultural Revolution period, society had the expectation that women would contribute equally to men economically, which sounds like Ms. W’s understanding of her gender role. This expectation also coincides with the values of more industrialized societies such as Hong Kong. However, this conflicts with Ms. W’s identity as a mother and a wife, which are roles that are traditionally considered important to women in Chinese culture. The patient shows difficulty integrating these different identities. She seems unable to assume these roles simultaneously at important times, such as when she immigrated to the United States to work but left her child behind. Although her extended family helps mitigate this conflict, Ms. W. nonetheless becomes anxious and depressed about it. These conflicts will be further addressed in the section “Overall Cultural Assessment,” which includes treatment planning.

Cultural Conceptualizations of Distress

Patients’ and providers’ explanations of the illness represent an important part of clinical care. An explanatory model can have several components. It is an attempt to understand how and why one becomes ill. In addition, explanatory models define the culturally acceptable symptoms of the illness. These cultural concepts of distress are strongly influenced by cultural values, and many are referenced in DSM-5 in sections titled “Culture-Related Diagnostic Issues.” Emotional symptoms of depression, such as depressed mood, for example, are not as acceptable as somatic symptoms, such as poor energy and insomnia, in many Asian cultures. The cultural explanations of the illness also define the behavior or role the sick individual is expected to assume. Finally, explanatory models contain elements of prognosis, which include ideas of the treatment options, in addition to the general course of the illness.

Some patients’ explanatory models are poorly defined, whereas others are quite fixed. Many patients entertain multiple explanatory models for a particular illness as well. For example, many patients will seek spiritual or religious assistance or alternative treatments, such as acupuncture or herbal medicine, in addition to medical treatment for their condition. Providers’ explanatory models also have a varying degree of heterogeneity for any given illness. It is essential that the clinician elicit the patient’s understanding of the cause of the

illness while explaining his or her own perspectives on the illness to the patient. This section illustrates the use of clinical methods and knowledge of the patient's cultural explanations of the illness to improve rapport with the patient.

Westermeyer (1989) discussed the usefulness of showing interest, clarifying the patient's explanatory models, facilitating the patient's story, and ensuring that the patient understands the interviewer's questions by having him or her restate the question. Clinicians can create rapport with patients by assessing the symptoms that patients are most comfortable expressing. In many cases, these are the somatic symptoms; treating these idioms of distress with respect and appropriate concern often facilitates rapport with the patient and lays the groundwork necessary to address more difficult yet clinically relevant issues. Patients who present with somatic complaints, for example, should be evaluated as if they were presenting for medical evaluation, with an exploration of precipitating, ameliorating, and aggravating factors. Next, the clinician should carefully review their complaints (review of symptoms), looking for the somatic symptoms of depression and anxiety, such as sleep or appetite disturbances, decrease in energy level, weight change, tachycardia, shortness of breath, and tremors. As the patient becomes more engaged, other more sensitive topics can be broached, such as the psychological symptoms of irritability, fears, thoughts of a gloomy future, crying spells, and nightmares, and then personal or family problems, as well as a history of trauma. These psychological symptoms need to be assessed directly and can include problems with concentration and memory, hallucinations, feelings of mistrust, intrusive thoughts, nightmares, and suicidal or homicidal ideas (Cheung 1987). For example, when dealing with newly immigrated Asian patients, a quiet, respectful demeanor is helpful, along with an acceptance of their use of traditional healers (Meyers 1992).

Successful treatment also requires the formation of a collaborative model that is acceptable to both provider and patient. This includes arriving at an agreed-on set of symptoms to treat, treatment expectations, and an understanding of the general course of the illness. It also may be helpful to involve members of the patient's primary support group. Difficulties arise when conflicts exist between the patient's and family members' explanatory models. Table 1–7 illustrates some potential consequences of these conflicts.

It is beyond the scope of this chapter to characterize the various types of explanatory models, but some of the more common types, such as moral,

Table 1–7. Conflicting explanatory models

Type of conflict	Consequences
Patient-provider	Diminished rapport, treatment nonadherence, treatment dropout
Patient-family	Lack of support, shame, family discord
Patient-community	Social isolation, stigmatization

spiritual/religious, magical, medical, and psychosocial stress, are described in this section (Ton 1996). Clinicians should keep in mind that these are general descriptions. A patient's particular model may incorporate elements of one or more of these common types. Moreover, patients may use more than one explanatory model, and these models may operate independently or even in conflict with each other. Efforts should therefore be made to clarify the patient's models through a thorough cultural assessment with a focus on the OCF cultural concepts of distress, the patient's explanation of his or her illness.

The *moral model* asserts that the patient's condition is caused by a moral defect such as laziness, selfishness, or having a weak will. Family members can be seen operating with this model, although patients themselves may use it as well. Typical statements include "You just have to work harder and get over this" or "I was able to overcome this on my own, so why can't you?" Treatments appropriate to this model typically include the patient's working to change his or her character flaw.

The *spiritual/religious model* maintains that illness is caused by spiritual or religious transgressions. As a result, angered spirits or the patient's higher power(s) can punish the patient. Typical interventions may include atonement, ritual appeasement of the angered spirits, or efforts to more closely follow prescribed spiritual or religious practices. Often, a spiritual leader is enlisted to consult with and advise a patient with such an affliction.

The *magical model* suggests that sorcery or witchcraft causes illness. Treatments may vary from culture to culture and may include finding the person who has caused the illness and/or involving a healer or shaman to counteract the spell.

Eliciting an explanatory model can be facilitated by the use of a set of questions developed by Arthur Kleinman et al. (1978). Table 1–8 has a list of eight questions that help to assess the patient's and family members' explanatory model of their illness, as well as their ideas about its treatment and prognosis (Kleinman et al. 1978).

Patients who attribute a biological etiology to the illness use a *medical model*. The medical model is not limited to traditional Western allopathic medicine, which is only one type of medical model. Others include traditional Chinese medicine, Ayurvedic medicine, homeopathy, osteopathy, and various herbal medicine traditions. In a national survey, Eisenberg et al. (1993) estimated that one of every three Americans used non-Western allopathic medicine remedies. Given the growing number of patients who are using alternative medical therapies and the drug interactions that can result, it is important for the clinician to adequately assess the patient's use of complementary and alternative medicine.

Individuals who use the *psychosocial stress model* may maintain that overwhelming psychosocial stressors cause their illness. Treatment usually includes having the patient attempt to reduce the social stressors.

The case of Ms. W. illustrates how an evaluation of a patient's explanatory model can provide significant insights into the clinical situation.

Case 1 (*continued*)

On further evaluation, Ms. W.'s clinicians found that emotional and psychological expressions of distress are not as supported as are physical expressions within Ms. W.'s family system. The patient felt distressed and saddened about her marriage. She also stated that her husband did not take her seriously. She reported that he responded to her concerns with promises, which were not kept. This is in contrast to how the patient's husband behaved after her multiple physical injuries. He went to great lengths to make sure she was comfortable. He fed her and protected her from intrusions from doctors and potential interviewers. He was, in essence, sacrificing time at work to be with her—something that she had tried to get him to do but was unable to prior to her injuries. However, Ms. W. and her husband did not acknowledge the significance of her social isolation and psychological distress in prompting her jump. Later, with psychoeducation, Ms. W.'s husband expressed interest in psychological follow-up for her depressive and anxious symptoms and asked how he could become better involved. The patient and her husband were most comfortable with the *psychosocial stress model*. Ms. W.'s suicide attempt indicated the seri-

Table 1–8. Kleinman’s eight questions

-
1. What do you call your illness? What name does it have?
 2. What do you think has caused the illness?
 3. Why and when did it start?
 4. What do you think the illness does? How does it work?
 5. How severe is it? Will it have a short or long course?
 6. What kind of treatment do you think the patient should receive? What are the most important results you hope he or she receives from this treatment?
 7. What are the chief problems the illness has caused?
 8. What do you fear most about the illness?
-

Source. Adapted from Kleinman et al. 1978.

ousness of her distress and, along with her physical injuries, sent a clear message to her husband of the need for some psychological intervention.

A discussion of cultural explanations of illness is incomplete without a discussion of culture-bound syndromes, now known as *cultural concepts of distress* in DSM-5, which can be understood as a cluster of symptoms and behaviors that are considered by a cultural group to be an illness and typically afflict only members of the given cultural group. Some examples of culture-bound syndromes are *ataques de nervios*, *shenjing shuairuo*, and *taijin kyofusho* (American Psychiatric Association 2013). A further discussion of various culture-bound syndromes, as they apply to the four major racial/ethnic groups, is found in the chapters that follow. An explanatory model can be assessed by asking patients how they explain their illness to themselves or others. CFI supplementary module 1, “Explanatory Model,” has some useful questions, such as “4. Do you know anyone else, or heard of anyone else, with this [PROBLEM]? If so, please describe that person’s [PROBLEM] and how it affected that person. Do you think this will happen to you too?” See Video 5–1, in which Dr. Boehnlein asks a patient, Mrs. Santiago, about her explanation of what happened to her (“I’m wondering how you explained that to yourself. Why do you think this happened?”) and if she knew of anyone else who had the same symptoms

(“When you were growing up, did you ever see anybody have any similar problems?”).



Video Illustration 5–1: Cultural concepts of distress—*ataque de nervios* (3:06)

Psychosocial Stressors and Cultural Features of Vulnerability and Resilience

The assessment of sociocultural stressors and supports is an essential part of any evaluation. In the case of a cultural formulation, attention needs to be given to the political history and current political situation between the patient’s cultural group(s) and the mainstream culture. A political history includes a history of racial or ethnic discrimination and relations between the individual’s country of origin and the host country in the case of immigrants and refugees. In addition, patients may identify sources of support commonly used in Western cultures, such as extended families, surrogate family networks (i.e., gangs), and religious organizations. Individuals may also experience stressors that are specific to their cultural group, such as conflicts caused by familial role reversals in immigrant families. The patient’s symptoms may vary with environment, indicating varying levels of sociocultural distress. Hence, his or her level of functioning and disability should be assessed across various relevant settings, including home, extended family, community of origin, and mainstream community.

Case 1 (continued)

Ms. W. has experienced several recent stressors. She feels alone, as she left behind most of her family supports as a result of her immigration to the United States. Her relationship with her husband worsens her situation because she feels a lack of intimacy and support from him. She is distressed about the discrimination she feels in her workplace, which has further frustrated her efforts to become productive and exacerbated her feelings of isolation. Her stressors are compounded by her inability to work; she remains away from her daughter and now must cope with disabilities. However, her husband has become quite involved and now serves as a significant source of support.

CFI supplementary module 4, “Psychosocial Stressors,” has five questions, such as “1. Are there things going on that have made your [PROBLEM] worse, for example, difficulties with family, work, money, or something else? Tell me more about that.” An example of the assessment of stressors and support can be seen in Video 3–3, in which Dr. Boehnlein and Mr. Jones discuss the stresses being put on Mr. Jones by his family.



Video Illustration 3–3: Role of the community (5:09)

Cultural Features of the Relationship Between the Individual and the Clinician

The provider’s cultural identity and the culture of mental health treatment can have a significant impact on a patient’s care. The U.S. Surgeon General (U.S. Department of Health and Human Services 2001c, p. 6) stated that “the culture of the clinician and the larger health care system govern[s] the societal response to a patient with mental illness. They influence many aspects of the delivery of care, including diagnosis, treatments, and the organization and reimbursement of services.” In this section, we discuss 1) key issues that arise from cultural conflicts between the provider and the patient, 2) the pitfalls of using the traditional psychiatric mental status examination, and 3) guidelines for the appropriate use of interpreters and cultural informants to mitigate the potential cultural conflicts and misunderstandings between providers and their patients.

Cultural Conflicts Between Provider and Patient

Conflicting explanatory models can result in poor adherence and rapport and the patient’s early termination of treatment. Cultural conflicts between provider and patient can cause more difficulties to arise in treatment. Clinicians who have clarity about their own cultural identity and their roles in mental health treatment are in a better position to anticipate these cultural dynamics and subsequently diminish the negative outcomes and enhance the positive outcomes of the clinical exchange. Thus, clinicians must maintain an awareness of their own biases, attitudes, and stereotypes. They must also consider the cultural influences on transference and countertransference in the clinical exchange (Table 1–9). Comas-Días and Jacobsen (1991) discussed these po-

tential influences in a seminal article on ethnocultural transference and countertransference.

Interethnic transference, as defined by Comas-Días and Jacobsen, involves the patient's response to an ethnoculturally different clinician. *Overcompliance*, for example, may occur when a sociocultural power differential exists between patient and clinician, resulting in superficial agreement on treatment in the clinical setting but nonadherence to treatment at home. *Denial of culture and ethnicity* occurs when the patient avoids discussing issues related to ethnicity and culture with the culturally different clinician, making cultural assessment more difficult. *Mistrust* and *hostility* may also occur in the context of the sociopolitical history between the patient's and the clinician's cultural groups. Unacknowledged cultural differences may exacerbate the suspicion. *Ambivalence* describes the patient's struggle with negative feelings about the culturally different clinician while he or she also develops attachment with the clinician. Likewise, ethnoculturally different clinicians may respond in a nontherapeutic manner, which Comas-Días and Jacobsen refer to as *interethnic countertransference*. Examples of this include a *denial of ethnocultural differences*, in which the clinician insists that the clinical encounter is not influenced by the cultural and social factors. Conversely, the *clinical anthropologist syndrome* occurs when the therapeutic process is derailed by an inordinate devotion to inquiring about the patient's cultural background to the exclusion of other interventions. The clinician also may have unresolved *guilt* about his or her cultural or social privilege in society or may *pity* the patient's position in society. This may manifest in *pity* or *aggression* toward the patient.

Although ethnocultural matching between patient and clinician can have significant therapeutic benefits (Takeuchi et al. 1995), such as a shared worldview through religious beliefs or a shared culture, as seen with matched pairs, and can create a better therapeutic relationship, there is also potential for destructive transference and countertransference. Comas-Días and Jacobsen described the potential negative transferences associated with this dyad. One example of interethnic countertransference is the *omniscient-omnipotent therapist*, which occurs when the patient overridealizes the clinician because of their shared cultural background. Alternatively, the patient perceives the clinician as a *traitor* because he or she has "sold out" to their shared culture. *Autoracism* can occur in transference as well, manifesting as the patient's belief that he or she is getting inferior treatment because the clinician is of the same

Table 1–9. Cultural influences on transference and countertransference

	Interethnic influences	Intraethnic influences
Transference	Overcompliance Denial of ethnocultural factors Mistrust Hostility Ambivalence	Omniscient-omnipotent therapist The traitor Autoracism Ambivalence
Countertransference	Denial of ethnocultural factors Clinical anthropologist syndrome Guilt or pity Aggression Ambivalence	Overidentification Distancing Cultural myopia Ambivalence Anger Survivor's guilt

Source. Adapted from Comas-Díaz and Jacobsen 1991.

ethnic group. The patient may also have ambivalent feelings about the therapist, at once appreciating the shared cultural background while being apprehensive about too much psychological closeness.

The clinician must also be aware of his or her negative countertransferences when treating patients from a similar ethnocultural background. Without this awareness and by choosing an activist approach when other approaches would be more beneficial, the clinician risks *overidentifying* with the patient. The clinician may also become judgmental of the patient: “If I’ve been able to overcome these cultural barriers through action, my patient should do the same.” This “us versus them” mentality is an extreme form of overidentification. In contrast, *distancing* can occur when the clinician has fears of overidentifying with the patient. *Cultural myopia* occurs when the clinician frames the therapy in cultural terms to the exclusion of other clinical perspectives. Furthermore, the patient’s experiences, shared from an ethnocultural perspective, may bring up painful memories for the clinician, which may result in *anger* or *guilt* toward the patient. Finally, the clinician’s own experience with unresolved cultural conflicts may emerge as *ambivalence* when addressing similar experiences of the patient.

CFI supplementary module 8, “Patient-Clinician Relationship,” can be used to assess the status of the relationship with its five questions for the patient and seven for the clinician after the interview has been completed. The most useful of these questions is “4. Sometimes differences among patients and clinicians make it difficult for them to understand each other. Do you have any concerns about this? If so, in what way?” An example of conflicts that may arise is seen in Video 6–2, when Dr. Boehnlein is asked by Ms. Diamond, “Are you Jewish?” She challenges him to understand her even though he is not Jewish.



Video Illustration 6–2: Transference and countertransference (5:18)

The case of Ms. W. illustrates some of the potential cultural conflicts that can arise between patients and clinicians from differing backgrounds, as well as the therapeutic potential of further cultural inquiry.

Case 1 (continued)

Ms. W.’s treating clinicians were troubled by her husband’s seemingly paternalistic attitude. On further inquiry, this was found to be consistent with the traditional role of the husband in Chinese culture as the protector and spokesman for his family. As the treatment team became more accepting of the husband’s traditional role, he became more interested in understanding more about Ms. W.’s emotional state and in learning about possible follow-up. This process was facilitated by one of the clinicians, who was a Mandarin-speaking Chinese American.

Mental Status Examination and Psychological Assessment

The cognitive and descriptive aspects of the mental status examination were developed in Western European, British, and American settings to describe the various cognitive, linguistic, perceptual, and affective domains of brain function. The result is that the examination is culturally biased. Accordingly, mental status measures must be elicited, described, and integrated in ways sensitive to the patient’s cultural identity and milieu. Patient responses are shaped by their culture of origin, educational level, and level of acculturation. For example, asking patients to state today’s date checks for the patient’s level of orientation. The patient may use a different calendar, such as the lunar calendar, and may not feel that dates are important information to recall. Some

cultures do not use clocks, and seasons vary around the world, depending on latitude (Westermeyer 1993). For some societies with strong oral history traditions, the patient's date of birth is irrelevant information. The interpretation of tests of abstraction, commonly tested by proverb interpretation, is difficult to assess because the meaning and wording of proverbs vary widely among different societies and language groups. Use of serial sevens to assess patients from illiterate cultures may be meaningless if their education has been limited to arithmetic with single digits. Differences in educational backgrounds may further limit the general usefulness of questions that assess fund of information. It is often an incorrect assumption that most people know much geography (Escobar et al. 1986). The patient's ability to name objects or remember items in short-term memory tests is affected by the patient's familiarity with the items chosen. Similarly, three-step commands should be adapted to be very simple (Hughes 1993). Escobar et al. (1986) concluded that the Mini-Mental Status Examination (MMSE) was influenced by age, educational level, ethnicity, and the language of the interview and recommended that it be revised to remove educational, social, and cultural artifacts when used in a Hispanic population.

Marsella and Kameoka (1989) observed that many of the tests and self-assessment questionnaires used in research have been developed with Western subjects and are not appropriate for use among ethnic minority patients because they lack cultural equivalence. Merely translating the items was stated to be insufficient and resulted in linguistic inequivalence because meanings and connotations changed and idioms of expression differed between languages. Rating scales for symptoms can be used if translated, back-translated, and validated (Marin and Marin 1991). Excellent examples of culturally appropriate tests include the Hopkins Symptom Checklist-25 (Mollica et al. 1987) and the Harvard Trauma Questionnaire (Mollica et al. 1992), both of which have been translated into Vietnamese, Laotian, and Cambodian. Finally, the interpretation of the results can be affected by using improper norms. Often, translated tests are not standardized for the testing group and must be properly normed on a representative patient group for meaningful results. Other sources of error included biased analysis, inaccurate assumptions and translation, and inappropriate instruments (Rogler 1989). Using translated editions of existing rating scales must be done with extreme caution unless these concerns are addressed.

The Language Barrier and the Use of Interpreters

Communication, which includes verbal and nonverbal components, is strongly influenced by language and culture. Effective communication is essential for a successful therapeutic interaction, leading to a more therapeutic relationship, improved adherence, and better health and mental health outcomes (Stewart 1995). Fifty million people in the United States speak a non-English language at home (U.S. Census Bureau 2009). Families with limited English proficiency are more likely to be less satisfied with their care, experience barriers to health care, report greater odds of having fair to poor health, and experience iatrogenic harm (Carrasquillo et al. 1999; Divi et al. 2007; Flores et al. 2005; Timmins 2002). Because of these significant disparities, health and mental health agencies receiving federal funding are mandated to provide language-appropriate services (U.S. Department of Health and Human Services 2001b). For patients with English as a second language, mental health encounters are even more difficult than standard medical interviews because communicating emotional and social distress essential to a psychiatric interview requires more than basic English proficiency. Hence, interpretation provided by well-trained and certified interpreters is critical to be able to provide adequate care to patients who are monolingual or have only basic English proficiency. The *therapeutic triad* incorporates the interpreter as an essential team member (Lee 1997b).

Figure 1–1 illustrates the importance of the positioning of individuals in the therapeutic triad. Each individual should have a clear view of the others in order to effectively communicate and receive nonverbal communication. The interpreter provides the critical verbal communication linkage between the clinician and the patient, in addition to helping to contextualize nonverbal communication when appropriate (see section “Cultural Informants” later in this chapter).

Interpreters should be trained in a set of competencies (Table 1–10) that clearly extend beyond simply speaking the patient’s language. Use of an untrained interpreter, such as a family member, a stranger in the vicinity, or an untrained staff member, causes significant problems because he or she likely lacks the necessary technical vocabulary or dual fluency. Problems may arise with confidentiality as well. Accuracy may also be affected if the ad hoc interpreter avoids communicating potentially embarrassing information. This can

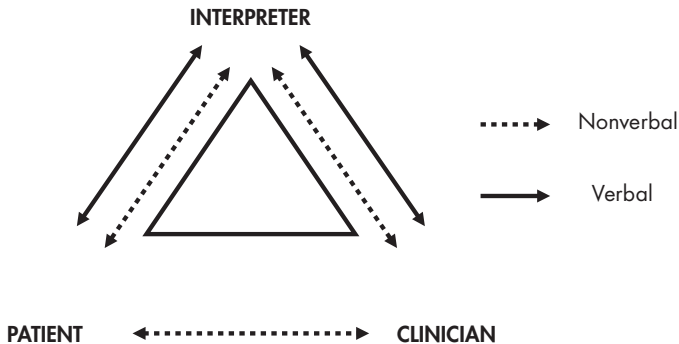


Figure 1–1. The therapeutic triad model.

Source. Adapted from Lee 1997b.

be particularly problematic when family members, such as young children and spouses, are used.

In addition to including an appropriately trained and matched interpreter, the clinician should be aware of three stages of interpreting (Lee 1997b). Prior to the clinical interview, the clinician should take time to prepare the interpreter by discussing such issues as the objectives of the interview, topics to be covered, the patient's background and current difficulties, the interpreter's cultural knowledge about these issues, and the desired length of the interview. This preinterview phase allows for rapport building in addition to helping to use the interview time more effectively. During the actual interview, it may be helpful for the clinician, interpreter, and patient to sit in a triangular format so that each can have face-to-face contact with the others. The clinician-interpreter team can use several translating formats depending on the situation (Lee 1997b).

Verbatim translation involves minimal participation by the interpreter and can be useful when attempting to translate factual or technical information. This can be done softly as the patient is speaking, which saves time but in-

Table 1–10. Competency criteria for interpreters

Technical

Good command of spoken and written English and language of the patient, including dialectical nuances

Ability to translate fine shades of meaning and nonverbal communication

Familiarity with psychiatric terminology and procedures

Cultural

Intimate knowledge of his or her ethnic community, including illness models, social and power structures, cultural values

Familiarity with culture of mainstream society and mental health service

Acts as a cultural broker

Interpersonal

Ability to get along with peers and staff and deal with conflicts arising from unrealistic expectations from clinician or patient

Understands own communication style and is aware of personal values, attitudes, and bias

Ability to assess areas of incompatibility with clinician or patient and react accordingly

Ethical

Ability to maintain a code of ethics that includes confidentiality, impartiality, and professional conduct

Other

Ability to effectively advocate for patient

Fine attention to detail and good memory

Flexibility in handling diverse situations

Source. Adapted from Lee 1997b.

creases the chance of miscommunication, or after the patient speaks, which can potentially double the interview time.

Summary interpretations emphasize the main points that the patient is attempting to communicate. This method can save time but increases the margin of error. This is particularly helpful when the patient requires a length of uninterrupted time to speak (e.g., during an emotionally charged topic).

Cultural interpretation involves conveying the patient's statements as well as his or her cultural contexts to more accurately reflect the patient's experience. After the interview is finished, during the postinterview phase, the clinician and interpreter should review the interview to clarify potential areas of confusion. The clinician and interpreter should also discuss their experience of working with each other to help build rapport and lay groundwork for future sessions with the interpreter. After the interview, or during key moments in the interview, the interpreter may be able to act as a *cultural informant*, also known as a *cultural broker* or *cultural consultant*, to help the clinician gain a better sense of the norms and values of the patient's ethnic or cultural group.

Pitfalls in the Use of Interpreters

The common practice of relying on young members of the family, who are more likely to be proficient in English, as interpreters for the older members tends to create confusing roles and responsibilities within the family system's dynamics. Obviously, in situations in which an interpreter may not be available on staff, the disadvantages of using a family member may be outweighed by the benefits of ensuring effective communication.

Another common occurrence in clinical settings is the temporary use of bilingual staff members who are not professional interpreters as interpreters as needed because of their bilingual skills. This practice also presents several limitations, such as the inability to check for accuracy of translation and ethical concerns about using employees to provide services for which they are not being adequately compensated.

Even when professional interpreters are used, numerous challenges result. Particularly relevant to mental health, concerns about confidentiality may inhibit some of the personal information that a patient may provide with a third party present. It is not uncommon, especially in some neighborhood health clinics, that patients and interpreters may be members of the same community, which may present serious confidentiality issues. Furthermore, despite

the assumed neutrality of the interpreter, he or she creates a triad that challenges some of the basic elements and assumptions of the more conventional therapeutic dyad. For example, differences and similarities between the interpreter and the patient in terms of nationality and socioeconomic, educational, and/or geographical (urban vs. rural) backgrounds may create particular interpersonal dynamics that become part of the clinical encounter. Such dynamics need to be adequately identified and analyzed because they may influence the information provided by the patient, as well as his or her behavior.

Cultural Informants

Cultural informants, also referred to as *cultural brokers* or *cultural consultants*, are not limited to interpreters. They can be members of a cultural group with various other roles, including religious or community leaders, primary care or mental health providers, or peers. Their function is to provide information and clarification about attitudes and perspectives of the patient's cultural group(s). Their expertise is derived from their level of participation within the cultural group. Cultural informants may not necessarily have specific knowledge or training in mental health. Hence, clinical questions about the broker's assessment of the patient's mental illness may be inappropriate. However, inquiries about the cultural group's general attitudes toward mental illness, explanatory models, and treatment pathways can be invaluable in helping the clinician understand and contextualize the cultural information that is obtained during an evaluation.

Overall Cultural Assessment

The overall assessment should highlight the key issues illustrated in the previous sections of the cultural formulation. Treatment planning should provide options that address these key issues without further exacerbating or creating new cultural conflicts. The clinician may support culturally specific treatment pathways (such as traditional healers or religious interventions); appropriate application of ethnopharmacological principles, as discussed in Chapter 11; the use of cultural consultants; and the use of culturally appropriate services. Often, interventions that are focused on a family or social level can be very helpful for patients as well. For example, in Video 2–2, note how Dr. Ton outlines the treatment plan while providing important support for Mr. Tran.



Video Illustration 2–2: Treatment negotiation—Asian American (5:04)

The overall assessment and treatment plans of Ms. W. are illustrated in the following case.

Case 1 (*continued*)

Ms. W. struggles with balancing three important roles in her life: that of a worker, a mother, and a wife. She uses an all-or-nothing strategy to cope with this struggle, which ultimately proves to be maladaptive for her, leading to further social isolation and distancing from her daughter. After her accident, Ms. W. is under significant stress because she is now unable to work and remains far from her daughter. She will likely continue to experience alienation from mainstream society. To some degree, she remains “a stranger in a strange land.” Because of this, she is at significant risk for worsening depression. However, her husband has become more available to her with her physical injuries and currently is her most important source of support.

A cultural assessment identifies several areas in which interventions will likely be helpful for Ms. W.:

1. Although Ms. W. reports feeling disappointed in her relationship with her husband, she would benefit from the treatment team’s efforts to bolster what is currently working in their relationship rather than destabilizing the relationship in this time of crisis. The clinician should validate and encourage the husband’s role in her care as a protector and as a caregiver. Both the patient and the husband need to have a positive and validating experience with the mental health system. If the husband feels alienated or “to blame” for the patient’s injuries and distress, he may disengage from the treatment, resulting in destabilization of the family system and ultimately a failure to follow through with mental health services. At a later point, when the family system is more stable and the patient has other sources of support, they would benefit from marital therapy.
2. The patient might benefit from exploring how she defines being a mother, a wife, and a worker because she is currently experiencing role conflict. Eventually, she might be encouraged to redefine her expectations of herself

to facilitate a more balanced integration, hence mitigating the cultural conflicts arising from these different identities.

3. The patient should be reunited with her family. They will become an even more important source of validation now that she will be unable to work for some time. Consideration should be given to helping facilitate her return to Hong Kong because the patient has experienced significant migration stress while transitioning to the United States and will likely continue to experience this stress if she remains in the United States.

Conclusion

Culture has an influence at every level of the mental health system. Its effects mediate access, service delivery, evaluation, treatment, and follow-up. Moreover, mental illness affects an individual's role in his or her cultural system. In the best case scenario, the cultural system can respond with a bolstering of sociocultural supports, but too often, the individual risks becoming stigmatized by his or her community. By understanding the individual's culture, the clinician can gain insight into the complex interplay between culture and mental illness, which will ultimately improve his or her ability to care for the individual. Although the ongoing pursuit of learning about the major cultural groups to which one's patients belong is important, that knowledge is often incomplete. The DSM-5 Outline for Cultural Formulation (OCF) and the Cultural Formulation Interview (CFI) discussed in this chapter provide a framework that helps guide and organize the clinician's exploration of an individual's multifaceted cultural identity and explanatory models of illness. The case example of Ms. W. and the other cases discussed in the chapter illustrate the practical application of the OCF and CFI, and the sections on working with interpreters and cultural informants help clinicians to make optimal use of the available resources. These tools and guidelines, when used with an attitude of openness to learn from the patient and his or her community, will significantly improve the clinician's ability to assess and treat the increasingly heterogeneous and multicultural patient community.

References

- Adebimpe VR: Overview: white norms and psychiatric diagnosis of black patients. *Am J Psychiatry* 138(3):279–285, 1981
- Alarcón RD, Westermeyer J, Foulks EF, et al: Clinical relevance of contemporary cultural psychiatry. *J Nerv Ment Dis* 187(8):465–471, 1999
- American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition. Washington, DC, American Psychiatric Association, 1994a
- American Psychiatric Association: Outline for cultural formulation and glossary of culture-bound syndromes, in *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition. Washington, DC, American Psychiatric Association, 1994b
- American Psychiatric Association: Outline for cultural formulation and glossary of culture-bound syndromes, in *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000
- American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition. Washington, DC, American Psychiatric Association, 2013
- Berry JW: Immigration, acculturation, and adaptation. *Appl Psychol* 46:5–34, 1997
- Carrasquillo O, Orav EJ, Brennan TA, et al: Impact of language barriers on patient satisfaction in an emergency department. *J Gen Intern Med* 14(2):82–87, 1999
- Cheung FM: Conceptualization of psychiatric illness and help-seeking behavior among Chinese. *Cult Med Psychiatry* 11(1):97–106, 1987
- Comas-Díaz L, Jacobsen FM: Ethnocultural transference and countertransference in the therapeutic dyad. *Am J Orthopsychiatry* 61(3):392–402, 1991
- Dennerstein L, Dudley E, Burger H: Well-being and the menopausal transition. *J Psychosom Obstet Gynaecol* 18(2):95–101, 1997
- Divi C, Koss RG, Schmaltz SP, et al: Language proficiency and adverse events in U.S. hospitals: a pilot study. *Int J Qual Health Care* 19(2):60–67, 2007
- Du N, Lu F: Assessment and treatment of posttraumatic stress disorder among Asians, in *Working With Asian Americans*. Edited by Lee E. New York, Guilford, 1997, pp 275–294
- Eisenberg DM, Kessler RC, Foster C, et al: Unconventional medicine in the United States: prevalence, costs, and patterns of use. *N Engl J Med* 328(4):246–252, 1993
- Escobar JI, Vega WA: Mental health and immigration's AAAs: where are we and where do we go from here? *J Nerv Ment Dis* 188(11):736–740, 2000
- Escobar JI, Burnam A, Karno M, et al: Use of the Mini-Mental State Examination (MMSE) in a community population of mixed ethnicity: cultural and linguistic artifacts. *J Nerv Ment Dis* 174(10):607–614, 1986

- Fàbrega H Jr: Culture and history in psychiatric diagnosis and practice. *Psychiatr Clin North Am* 24(3):391–405, 2001
- Flores G, Abreu M, Tomany-Korman SC: Limited English proficiency, primary language at home, and disparities in children's health care: how language barriers are measured matters. *Public Health Rep* 120(4):418–430, 2005
- Gaw AC: *Concise Guide to Cross-Cultural Psychiatry*. Washington, DC, American Psychiatric Publishing, 2001
- Group for the Advancement of Psychiatry Committee on Cultural Psychiatry: *Cultural Assessment in Clinical Psychiatry*. Washington, DC, American Psychiatric Publishing, 2002
- Heilemann MV, Lee KA, Stinson J, et al: Acculturation and perinatal health outcomes among rural women of Mexican descent. *Res Nurs Health* 23(2):118–125, 2000
- Hsu FL: *Rugged Individualism Reconsidered: Essays in Psychological Anthropology*. Knoxville, University of Tennessee Press, 1983
- Hughes CC: Culture in clinical psychiatry, in *Culture, Ethnicity, and Mental Illness*. Edited by Gaw AC. Washington, DC, American Psychiatric Press, 1993, pp 3–41
- Kessler RC, McGonagle KA, Zhao S, et al: Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: results from the National Comorbidity Survey. *Arch Gen Psychiatry* 51(1):8–19, 1994
- Kessler RC, Sonnega A, Bromet E, et al: Posttraumatic stress disorder in the National Comorbidity Survey. *Arch Gen Psychiatry* 52(12):1048–1060, 1995
- Kessler RC, Stang PE, Wittchen HU, et al: Lifetime panic-depression comorbidity in the National Comorbidity Survey. *Arch Gen Psychiatry* 55(9):801–808, 1998
- Kinzie JD: The historical relationship between psychiatry and the major religions, in *Psychiatry and Religion*. Edited by Boehnlein JK. Washington, DC, American Psychiatric Press, 2000, 3–26
- Kirmayer LJ: Cultural variations in the clinical presentation of depression and anxiety: implications for diagnosis and treatment. *J Clin Psychiatry* 62 (suppl 13):22–28, discussion 29–30, 2001
- Kleinman A: *Rethinking Psychiatry*. New York, Free Press, 1988
- Kleinman A, Eisenberg L, Good B: Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. *Ann Intern Med* 88(2):251–258, 1978
- Koenig HG, Larson DB: Religion and mental health: evidence for an association. *Int Rev Psychiatry* 13:67–78, 2001
- Kulhara P, Chakrabarti S: Culture and schizophrenia and other psychotic disorders. *Psychiatr Clin North Am* 24(3):449–464, 2001
- Lambda Legal: *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People With HIV*. New York, Lambda Legal, 2010

- Lee E: Assessment and treatment of Chinese-American immigrant families, in *Minorities and Family Therapy*. Edited by Saba GW, Karrer BM, Hardy KV. New York, Haworth, 1990, pp 99–122
- Lee E: Chinese-American families, in *Working With Asian Americans*. Edited by Lee E. New York, Guilford, 1997a, pp 46–78
- Lee E: Cross-cultural communication: therapeutic use of interpreters, in *Working With Asian Americans*. Edited by Lee E. New York, Guilford, 1997b, pp 477–489
- Lu FG, Lim RF, Mezzich JE: Issues in the assessment and diagnosis of culturally diverse individuals, in *American Psychiatric Press Review of Psychiatry*, Vol 14. Edited by Oldham J, Riba M. Washington, DC, American Psychiatric Press, 1995, pp 477–510
- Lukoff D, Lu FG, Turner R: Cultural considerations in the assessment and treatment of religious and spiritual problems. *Psychiatr Clin North Am* 18(3):467–485, 1995
- Marin G, Marin B: *Research With Hispanic Populations*. Newbury Park, CA, Sage, 1991
- Marsella AJ, Kameoka VA: Ethnocultural issues in the assessment of psychopathology, in *Measuring Mental Illness: Psychometric Assessment for Clinicians*. Edited by Wetzler S. Washington, DC, American Psychiatric Press, 1989, pp 229–256
- Matsumoto D: *Culture and Psychology*. San Francisco, CA, Brooks/Cole, 1996
- Meyers C: Hmong children and their families: consideration of cultural influences in assessment. *Am J Occup Ther* 46(8):737–744, 1992
- Mezzich JE, Otero AA, Lee S: International psychiatric diagnosis, in *Comprehensive Textbook of Psychiatry*, 7th Edition. Edited by Kaplan HI, Sadock BJ. Baltimore, MD, Williams & Wilkins, 2000, pp 847–849
- Mezzich JE, Berganza CE, Ruiperez MA: Culture in DSM-IV, ICD-10, and evolving diagnostic systems. *Psychiatr Clin North Am* 24(3):407–419, 2001
- Mollica RF, Wyshak G, de Marneffe D, et al: Indochinese versions of the Hopkins Symptom Checklist-25: a screening instrument for the psychiatric care of refugees. *Am J Psychiatry* 144(4):497–500, 1987
- Mollica RF, Caspi-Yavin Y, Bollini P, et al: The Harvard Trauma Questionnaire: validating a cross-cultural instrument for measuring torture, trauma, and posttraumatic stress disorder in Indochinese refugees. *J Nerv Ment Dis* 180(2):111–116, 1992
- Muskin PR: *Complementary and Alternative Medicine and Psychiatry*. Washington, DC, American Psychiatric Press, 2000
- Phinney JS: Ethnic identity and self-esteem: a review and integration, in *Hispanic Psychology: Critical Issues in Theory and Research*. Edited by Padilla AM. Thousand Oaks, CA, Sage, 1995, pp 57–71

- Pulchaski C: Spiritual assessment in clinical practice. *Psychiatr Ann* 36:150–155, 2006
- Rogler LH: The meaning of culturally sensitive research in mental health. *Am J Psychiatry* 146:296–303, 1989
- Rogler LH: Culture in psychiatric diagnosis: an issue of scientific accuracy. *Psychiatry* 56(4):324–327, 1993
- Stewart MA: Effective physician-patient communication and health outcomes: a review. *Can Med Assoc J* 152:1423–1433, 1995
- Takeuchi DT, Sue S, Yeh M: Return rates and outcomes from ethnicity-specific mental health programs in Los Angeles. *Am J Public Health* 85(5):638–643, 1995
- Timmins CL: The impact of language barriers on the health care of Latinos in the United States: a review of the literature and guidelines for practice. *J Midwifery Womens Health* 47(2):80–96, 2002
- Ton H: Health and cultural change: perspectives of a Vietnamese extended family. Unpublished master's thesis. University of California, Berkeley, 1996
- Tsai JL, Ying Y, Lee PA: The meaning of “being Chinese” and “being American”: variation among Chinese American young adults. *J Cross Cult Psychol* 31(3):302–332, 2000
- U.S. Census Bureau: Table 4, in *Projections of the Population by Sex, Race, and Hispanic Origin for the United States: 2010 to 2050 (NP2008-T4)*. Washington, DC, U.S. Census Bureau, August 14, 2008. Available at <http://www.census.gov/population/projections/data/national/2008/summarytables.html>. Accessed April 25, 2014.
- U.S. Census Bureau: *Language Spoken at Home by State: 2009*. Washington, DC, U.S. Census Bureau, 2009. Available at: <http://www.census.gov/compendia/statab/2012/tables/12s0054.pdf>. Accessed April 25, 2014.
- U.S. Census Bureau: *Overview of Race and Hispanic Origin: 2010*. Washington, DC, U.S. Census Bureau, March 2011. Available at: <http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf>. Accessed November 3, 2011.
- U.S. Department of Health and Human Services: *Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD, U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General, 2001a
- U.S. Department of Health and Human Services: *National Standards for Culturally and Linguistically Appropriate Services in Health Care, Final Report*. Rockville, MD, Office of Minority Health, 2001b
- U.S. Department of Health and Human Services: *Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General [Executive Summary]*. Rockville, MD, U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General, 2001c

Westermeyer JJ: Psychiatric Care of Migrants. Washington, DC, American Psychiatric Press, 1989

Westermeyer JJ: Cross-cultural psychiatric assessment, in Culture, Ethnicity, and Mental Illness. Edited by Gaw AC. Washington, DC, American Psychiatric Press, 1993, pp 125–144

This page intentionally left blank

Applying the DSM-5 Outline for Cultural Formulation and the Cultural Formulation Interview

A Resident's/Early Career Psychiatrist's Perspective

Angel Caraballo, M.D.

Jennifer Robin Lee, M.D.

Russell F. Lim, M.D., M.Ed.

Everyone brings his or her own personal and professional culture to an interaction; culture influences many aspects of psychiatric illness, including illness manifestation, coping, and help-seeking behavior. The updated DSM-5

The authors would like to acknowledge the contributions of Hamada Hamid, M.D., Joy McQuery, M.D., and Yanni Rho, M.D. to the first edition of the *Clinical Manual of Cultural Psychiatry*. Their work is included in this revised chapter, which was updated by Drs. Caraballo and Lim.

Outline for Cultural Formulation (OCF) is a critical framework for evaluation that belongs in the standard psychiatric evaluation. DSM-5 (American Psychiatric Association 2013) introduces another important innovation, the Cultural Formulation Interview (CFI), which gives the clinician sample questions to perform a culturally appropriate assessment. Throughout this chapter, we refer to the CFI, and its 12 supplementary models when appropriate, to illustrate further how to complete a cultural formulation. As noted in Chapter 1, “Assessment of Culturally Diverse Individuals,”

factual knowledge about cultural groups is essential but can have limited utility without a conceptual framework to organize and to make sense of the information. Furthermore, the clinician will encounter many patients who are affiliated with one or more cultural groups, of which he or she may have inadequate knowledge. In these instances, an organizing framework is helpful to guide the clinician to areas of potentially important inquiry. (p. 7)

This chapter was written by former psychiatry residents and early career psychiatrists for psychiatrists in training or others who may not be as familiar with cultural implications in mental health in the hope that it will be helpful in the assessment and treatment of culturally diverse patients. The OCF is a hypothesis-generating tool and is just one part of the overall assessment that can help the clinician sort out the patient’s problems within his or her cultural context. It is important to note that conclusions drawn at the first visit may be tentative and subject to change as more information is obtained.

How does one apply the OCF practically to a clinical encounter? What kinds of things does the clinician consider when thinking about how to apply the cultural formulation to the standard psychiatric evaluation? Here are some tips to consider in working with patients from diverse cultural backgrounds.

- Building rapport is critical. Allow the patient to guide the process of getting to know him or her better. As a general rule, ask the least intrusive questions first.
- Explain the process of the interview and evaluation and elicit questions and concerns along the way to help build trust. Normalize the line of questioning and respond appropriately to discomfort and doubt. Trust will be especially important when working with undocumented migrants and patients with long legacies of distrust of the medical profession.

- A critical part of the evaluation is respecting patients “where they are.” Do not assume anything about the patient’s cultural identity; be curious and sensitive in determining his or her reference group, what terms he or she feels sensitive about or shamed by, and what types of experiences he or she has had with mental health professionals or others of your cultural background. Also, allow for a curiosity that may come from your patient about your cultural background.
- Even if you think that patients or families understand English (or your language) well, do not be afraid to use interpreter or translator services. Language is incredibly nuanced. If the facility does not have interpreters, national translation telephone services, such as Language FôN (<http://languagefon.com>), Certified Languages International (www.certifiedlanguages.com), 1-800-Translate (www.1-800-translate.com), and Language-Line Solutions (www.language-line.com), can be used. All or most of these services charge a fee. Using family members as interpreters is discouraged for the following reasons: In addition to the issues surrounding patient confidentiality, the patient may withhold information because he or she may not want to share information because it may be too difficult or too traumatic to discuss in the presence of family members, he or she may fear repercussion (e.g., in cases of domestic violence), or he or she may want to “save face.” Another issue is that what is reported by the family member simply may be misunderstood, especially when children are used as interpreters.
- Be very sensitive to the fact that for many people, great stigma is attached to seeking help for mental illness. Be aware of discomfort, fear, and your reactions to what you might perceive as resistance (Lu 2005).
- Obtain releases to speak to family, friends, community leaders, and others who are important in your patient’s life if he or she wants to have these people involved in his or her care. Be aware of minimized reports of symptoms from all due to their fears of stigmatizing the patient and their fears of mental illness (Lu et al. 1995).
- Be aware of cultural dissonance and divergence in beliefs between the clinician, the patient, and the patient’s friends, family, and others (Henderson and Nguyen 2004). Remember, the clinician also brings his or her own cultural biases and belief systems to the interaction.

- Consider culturally and linguistically appropriate diagnostic screening questions, interviews, and schedules to help determine a differential diagnosis.
- Remember, there is not a 1:1 conversion between cultural concepts of distress and DSM-5 (American Psychiatric Association 2013) diagnostic criteria; focus on symptoms that need to be addressed and collaborate on alleviation of them (Guarnaccia and Rogler 1999).
- Do not overattribute or underattribute symptoms to culture. After obtaining consent, check in with others (such as family, reference group community members, or cultural consultants) to get a better sense of cultural norms.
- In some situations, you might feel limited in your knowledge and skills in successfully performing and integrating a cultural formulation into your assessment. In such instances, consultation with an individual who is knowledgeable about the patient's culture may be helpful. One should never hesitate to use a cultural broker or cultural consultant, someone who knows the culture well and can discuss it with the clinician.
- Use well-known mnemonics to help you decide which questions to ask if you need a "quick," culturally appropriate evaluation to help determine what is cultural and what is psychopathological. Some examples appear in Table 2–1.
- Finally, the questions in this chapter are only helpful suggestions, not an absolute checklist. They should not be construed as the definitive protocol for performing a cultural formulation because additional questions may be important and relevant for any particular clinical encounter.

Ultimately, the clinician will tailor his or her use of the OCF according to the type and setting of the evaluation (e.g., one-time emergency department visit vs. ongoing therapy).

Cultural Identity of the Individual

Cultural identity encompasses a very broad array of aspects (see Chapter 1, "Assessment of Culturally Diverse Individuals," Table 1–4). The role of the clinician is to encourage the patient to describe the cultural identity factors that are important to him or her (Lu 2005).

Table 2–1. Useful mnemonics for cultural formulation

LEARN	ETHNIC	TRANSLATE	BATHE
Listen with sympathy	Explanation of symptoms	Trust	Background
Explain your perceptions of the problem	Treatment	Roles of interpreter	Affect (feeling state of patient)
Acknowledge and discuss differences and similarities in explanation of illness	Healers (previous use)	Advocacy (how will this occur?)	Trouble (what situation troubles you most?)
Recommend treatment	Negotiate treatment	Nonjudgmental attitude	Handling (how are you handling this?)
Negotiate treatment	Intervention	Setting	Empathy
	Collaboration	Language (what methods of communication will occur?)	
		Accuracy of information collected	
		Time (how will this be managed in the encounter?)	
		Ethical issues (such as confidentiality)	

Although it may seem trivial, the way in which these questions are asked is extremely crucial because it will set the tone for the rest of the interview. For example, if the patient feels that he or she is being judged from the beginning of the interview, it will be very difficult to have him or her open up and cooperate during the rest of the interview.

Language

The patient's preferred language should be assessed first to facilitate communication between patient and therapist. Language is an extremely important aspect of cultural identity.

It is important to assess spoken language early in the interview. It can give the clinician an approximation of level of acculturation and ensure that the diagnostic assessment is accurate. For example, it may not be apparent that a patient has psychotic symptoms until the clinician assesses him or her in his or her native language so that the patient may be able to express the full complexity of his or her thoughts. It also will help the clinician determine whether an interpreter is needed for the session.

Knowing how to speak a different language from that of the host country is a source of pride and acceptance for some, but it can be a source of embarrassment for others. Therefore, it is very important to assess the patient's level of comfort and to determine his or her preference for the language in which sessions are to be conducted. Some language questions to consider are the following:

- The primary questions to address are: What language(s) do you speak? Which language do you prefer? Do you know how to write or read in any language other than English?
- Secondary questions include: What languages did you speak while growing up? Do you speak to your family in a language other than English? What language(s) do you speak at work?
- CFI supplementary module 6, "Cultural Identity," offers some questions for language assessment similar to those described above, such as questions 8–13 below (American Psychiatric Association 2013).
 8. What languages do you speak fluently?
 9. What languages did you speak growing up?

10. What languages are spoken at home? Which of these do you speak?
11. What languages do you use at work or school?
12. What language would you prefer to use in getting health care?
13. What languages do you read? Write?

Place of Origin, Socioeconomic Status, and Relationships and Sexual Orientation

After you have established the language of communication, the official interview should start with an assessment of the chief complaint. An appropriate question would be “What brings you here today?,” which is the first question of the CFI. The second part of the OCF, “Cultural Concepts of Distress,” discusses how to incorporate the OCF into the history of present illness (HPI) (see the section “Cultural Concepts of Distress” in this chapter).

For those patients who cannot formulate a chief complaint, you can start with the following basic questions:

- Where were you born?
- Who lives with you?
- How do you support yourself?

This will allow the clinician to create rapport with the patient and start the flow of the interview naturally. The first question is actually the first question from CFI supplementary module 6, “Cultural Identity,” which is followed by six more cultural identity questions (see Appendix 1, “DSM-5 Outline for Cultural Formulation, Cultural Formulation Interview, and Supplementary Modules”). With these three questions, you can obtain information about *socioeconomic status, relationships and sexual orientation, and place of origin* and get a sense of severity of illness (for instance, a socially isolated person living on psychiatric disability). Some additional questions to ask are:

- **Place of origin:** Where were you born? If the patient is from another country, *as determined by the patient’s answer*: How much contact do you have with family or friends who still live in that country? How often do you visit your country of origin?
- **Socioeconomic status:** How do you support yourself? To what extent do you have trouble affording the basics of life such as housing and food? How does

your current socioeconomic status affect your life? Has your lifestyle changed since you came to the United States (if the patient is an immigrant)?

- **Sexual orientation/relationship status:** Are you currently in a relationship? If yes, is your partner a man or a woman? This area of inquiry may be very sensitive for persons from some cultures. If the patient has not been involved in a relationship, you should inquire about sexual orientation gently and nondirectively. CFI supplementary module 6, “Cultural Identity,” addresses sexual orientation in questions 29–32 (replace the word “PROBLEM” with the patient’s own words) (American Psychiatric Association 2013):
 29. How would you describe your sexual orientation (e.g., heterosexual, gay, lesbian, bisexual, queer, pansexual, asexual)?
 30. Do you feel that your sexual orientation has influenced your [PROBLEM] or your health more generally?
 31. Do you feel that your sexual orientation influences your ability to get the kind of health care you need for your [PROBLEM]?
 32. Do you feel that health care providers have assumptions or attitudes about you or your [PROBLEM] that are related to your sexual orientation?

Ethnicity and Race

The same principles described above also apply to questions about ethnicity and race, which are crucial components of an individual’s cultural identity. National, ethnic, and racial background questions to consider are the following:

- **Ethnicity:** Do you consider yourself part of any specific ethnic group? If so, which ethnic group do you identify with the most? Are you bicultural or “all-American,” or do you identify primarily with your culture of origin?

It is important to keep in mind that identifying with a specific ethnic group does not imply that everyone is the same. For example, multiple subgroups are included in the terms *Asian American*, *Native American*, *Latino*, and *Hispanic*.

Many other subgroups within a certain ethnic group can also affect the way patients explain their illness. Inquiring about these other components

will also facilitate the development of rapport because patients feel that the clinician is interested in them as individuals and not just in their illnesses.

- **Race:** How do you identify yourself in terms of race?

CFI supplementary module 6, “Cultural Identity,” offers questions 2–7 on cultural identity:

2. Where were your parents and grandparents born?
3. How would you describe your family’s national, ethnic, and/or racial background?
4. In terms of your background, how do you usually describe yourself to people outside your community? Sometimes people describe themselves somewhat differently to members of their own community. How do you describe yourself to them?
5. Which part of your background do you feel closest to? Sometimes this varies, depending on what aspect of your life we are talking about. What about at home? Or at work? Or with friends?
6. Do you experience any difficulties related to your background, such as discrimination, stereotyping, or being misunderstood?
7. Is there anything about your background that might impact on your [PROBLEM] or impact on your health or health care more generally?

Of these questions, question 4 might be the most helpful because it asks the patient to describe his or her identity to an outsider to his or her group, which is usually what happens during a psychiatric assessment.

The CFI has one question that addresses cultural identity:

8. For you, what are the most important aspects of your background or identity?

Age, Religion/Spirituality, and Education

Finally, question 9 from the CFI asks the patient if his or her cultural identity has an impact on his or her problem: “Are there any aspects of your background or identity that make a difference to your [PROBLEM]?” Some of the other aspects of cultural identity are already incorporated into a general psy-

chiatric evaluation. Examples include age; spirituality, religion, or moral traditions; and education. However, more detailed questions will help clinicians to better understand the importance that these aspects play for patients and how they identify culturally. Questions about age; spirituality, religion, or moral traditions; and education to consider are:

- **Age:** How old are you? Age is very important for some people but not for others. What role does age play in your life?

Other very important aspects of one's cultural identity are religion/spirituality and education. These aspects also play a major role in how a patient explains his or her stressors and the supports in his or her life. An excellent religious/spiritual screening tool is FICA (Koenig 2013), which asks four questions:

F—Is religious **Faith** an important part of your day-to-day life? This question could be followed by associated questions about formal religious identity and level of spirituality.

I—How has faith **Influenced** your life, past and present? This question may uncover important spiritual experiences.

C—Are you currently part of a religious or spiritual **Community**? This question helps clarify the role a spiritual community might play in treatment interventions.

A—What are the spiritual needs that you would like me to **Address**? This question allows the clinician to identify spiritual areas that may become part of a treatment plan.

CFI supplementary module 5, “Spirituality, Religion, and Moral Traditions,” offers 16 questions for the assessment of the role of religion in the patient's life. Particularly helpful in the cultural formulation are questions 9–12, which ask the patient about the relationship between his or her faith and the presenting issue (American Psychiatric Association 2013).

9. How has [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] helped you cope with your [PROBLEM]?
10. Have you talked to a leader, teacher or others in your [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] community, about your [PROBLEM]? How have you found that helpful?

11. Have you found reading or studying [BOOK(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S), (e.g., BIBLE, KORAN)], or listening to programs related to [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] on TV, radio, the Internet or other media [e.g., DVD, tape] to be helpful? In what way?
 12. Have you found any practices related to [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)], like prayer, meditation, rituals, or pilgrimages to be helpful to you in dealing with [PROBLEM]? In what way?
- **Education:** How far did you go in school? How important is education for you and for your family members?

Immigration History

Immigration history is useful when patients have come from another country. The following mnemonic is like the journalism question—who, what, where, when, and why—plus how (McGill University, Division of Social and Transcultural Psychiatry 2000):

- **Who** did you leave?
It is common for families to be separated during migration, sometimes involuntarily.
How to ask: Who came with you and who are the important people in your life who weren't able to come? Do you have plans to be reunited?
- **What** did you leave?
It is important to find out whether your patient wanted to immigrate. Patients who did not want to move will have a more difficult time adjusting.
How to ask: What was the economic and political situation in your country when you left?
- **(Through) Where** did you leave?
This can be a *sensitive* question. Sometimes the immigration journey itself can be a traumatic experience. Be particularly attuned to this if your patient is a refugee or has an undocumented status. Entering the United States without legal paperwork can be expensive (people may pay a “coyote” or “snakehead,” professional people smugglers, to transport them

across the border or into the United States) and traumatizing. Asking first about the immigration journey can help the clinician find out if he or she is touching on a traumatizing topic.

How to ask: What was your immigration journey like? What was your immigration route?

- **When** did you leave?

Refugees, in particular, may have been displaced from their country of origin for years in refugee camps.

How to ask: When did you leave home, and how long was your journey to this country?

- **Why** did you leave?

Did the patient immigrate for economic reasons, flee the country of origin as a refugee, and so on?

Immigrants who have no possibility of returning to their country of origin are more likely to find the process of acculturation more stressful and hence be more symptomatic. Immigrants who can frequently visit their home country or who are not planning to stay permanently in the United States are not faced with the full task of abruptly adjusting to a new culture and may have a less stressful experience (Tseng 2001).

How to ask: Why did you leave your country? Was it your choice? Do you have a possibility of returning home?

- **How [legally]** did you leave (*immigration status*)?

This can be a *sensitive* question, especially if your patient has an *undocumented* status. It also can be a tremendous source of fear and point of vulnerability. People who do not have a legal status may be afraid of deportation and afraid of accessing services, which greatly impedes their acculturation.

How to ask: Is your legal status a source of stress for you? I ask this because I know that many people are afraid to get the services they need because they do not have a documented legal status. This places them in a stressful situation that affects their health. It is helpful for me to understand the obstacles you are facing.

Premigration Difficulties

CFI supplementary module 11, “Immigrants and Refugees,” offers 18 questions to assess the impact of migration on a patient’s life. Questions 5 and 6 would help in the assessment of posttraumatic stress disorder (American Psychiatric Association 2013):

5. Prior to arriving in _____ (HOST COUNTRY), were there any challenges in your country of origin that you or your family found especially difficult?
6. Some people experience hardship, persecution, or even violence before leaving their country of origin. Has this been the case for you or members of your family? Can you tell me something about your experiences?

Inquiring about cultural identity will aid in establishing the proper diagnosis, which may otherwise be influenced by erroneous assumptions, and will lead to the establishment of a treatment plan that is culturally appropriate for the individual.

Level of Acculturation

Cultural identity can be a source of distress or support for an individual. For example, for some people, having to identify with a specific group can be a source of distress because this sets them apart from the majority, whereas others have a great fear of becoming acculturated with the majority. Furthermore, they may have intrapsychic conflicts about their cultural identity. It is important to properly assess the level of acculturation of a patient. Level of acculturation questions to ask are:

- How do you feel about your culture of origin?
- How involved are you with your culture of origin?
- Which community organizations are you involved with, and what role do you play in them?
- Do you belong to any group with people from your culture of origin (e.g., a religious organization or leisure setting) or any groups with people mostly from the United States?

- Do you have any friends from your culture of origin or a culture other than yours? How do you relate to these people?
- How do you socialize with members of your extended family?
- How do you view the way you are treated by people from other cultures?
- What type of discrimination have you experienced?
- Have you ever experienced racism?
- Have any of these experiences transformed your life in any way?

Cultural Concepts of Distress

SPESial TEsT Mnemonic

Cultural concepts of distress can be addressed by using the mnemonic **SPESial TEsT**, which refers to Symptoms, Precipitators and Explanation, Severity of dysfunction, Treatment history, Experiences with help seeking, and type of Treatment. Note that most of the information in this section can be incorporated into the standard HPI or the review of systems.

- **Symptoms:** What are the patient's worst symptoms or distressing experiences? Elicit idioms of distress and culture-bound syndromes. See the section "Examples of Specific Cultural Concepts of Distress and Idioms of Distress" for examples.

How to ask: What kinds of things are you experiencing? How has this affected your life? What are your worst symptoms? What do you call these symptoms?

Point to note: Some of these experiences are self-limited and may not require treatment.

- **Precipitators and Explanation** for symptoms and distress: Describe the course of illness, symptoms, or distressing experiences.

How to ask: How do you explain what is happening? When did it start, and what started it? How do your friends, family, community, or those who know you best and/or are most like you (reference group such as specific ethnic or cultural affiliation, race, religious affiliation, sex, age, or acculturative stage) explain what is happening?

Points to note: These explanations can include religious beliefs, magical explanations, exhaustion, perceived discrimination, disabilities, character weakness and moral judgment, and biological explanations. Explanations can also include beliefs related to specific subcultures, witchcraft or voodoo, spirits or demons, family legacy, migration histories, and humoral explanations. It will be important to remember how the patient self-identifies and with which cultural group(s) he or she identifies. For example, level of acculturation may be very important because a second-generation Chinese American male might have more Western belief influences in his explanations than would a new immigrant. The following questions are from the CFI:

2. Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them?
 3. What troubles you most about your problem?
 4. Why do you think this is happening to you? What do you think are the causes of your [PROBLEM]?
- **Severity or level of dysfunction** and meaning of symptoms and distressing experiences in reference to the host culture or culture of origin.

How to ask: What does it mean that you are experiencing these symptoms? How serious are these symptoms for you, and does that have any meaning? Do you worry about what your symptoms might mean (Kleinman et al. 1978)?

Points to note: The clinician should inquire about level of function as he or she would in a typical psychiatric evaluation because this will help guide the treatment decisions. The clinician will be able to derive a more implicit versus explicit sense of how these symptoms interface with the patient's own culture of origin and the host culture, but the clinician can ask additional questions, such as "Are these symptoms affecting your work? Has your boss made any comments or complaints?," to elicit how these symptoms are perceived in the host culture.

The following questions can be asked as part of the psychiatric history or medical history.

- **Treatment history:** This is more a question of actual treatments that have been tried in the past.

How to ask: What kinds of treatments have you received up until now? How would someone from your reference group (such as friends, family, geographic location, and religion) be treated, or what advice have you gotten on how to deal with the symptoms?

Point to note: Treatments can come in any form, such as prayer, stress reduction exercises, having family and friends leave the patient alone, doctors, faith healers, shamans, alternative and traditional medicines, homeopathy, Ayurveda, cupping or coining, diet, meditation, and supplements.

- **Experiences with help seeking:** This is more a question of patients' emotional and overall experience with trying to get help for their problems. This will greatly influence how they perceive future (and current) help-seeking attempts and treatment options.

How to ask: What kind of experience have you had with previous types of treatment? What types of experiences have others that you know had (e.g., did anyone in your family or friends see a psychiatrist)? What has helped the most? In your culture, is there shame associated with seeking psychiatric help? Who experiences the shame?

Point to note: *Everyone* has had some emotional response to help-seeking attempts. Additional questions can include, "What did it feel like for you when you previously sought help? How would you have wanted it to be different?" People will refer to their own experiences as well as the experiences of their family and friends, so it will be important to ask about those experiences as well.

- **Treatment:** What do you think the course of your presentation is, and what type of treatment would you like now? What do you fear most about your symptoms?

How to ask: What do you think will happen now? What do you fear or worry about most regarding your symptoms and your treatment? What do you think will be most helpful at this point? These treatments can include talk therapy (about past and present experiences), receiving advice, exercise, medications, alternative treatments, and psychoeducation.

Points to note: It is important to remember that many treatment options can coexist at the same time. There will need to be thought given to what makes the most sense and what is the most helpful for the patient.

The relationship between the patient and the clinician is important to consider: it will be important to elicit the patient's expectations about you and your role in the treatment, such as authoritarian figure or cooperative figure. Remember to be aware of the differences between the clinician and the patient regarding illness beliefs and treatment beliefs. It is important to be aware of when the clinician's specific beliefs are influencing the care of his or her patient.

Question 4 from the CFI is useful in eliciting cultural concepts of distress: "Why do you think this is happening to you? What do you think are the causes of your [PROBLEM]?" (American Psychiatric Association 2013). CFI supplementary module 1, "Explanatory Model," can further elaborate on the patient's conception of the problem with its 14 questions: 2 on the general understanding of the problem, 3 on illness prototypes, 4 on causal explanations, 3 on the course of illness, and 2 on help seeking and treatment expectations.

Case 1 (Video 5)

Mrs. Santiago is a 52-year-old twice-married Nicaraguan woman living in San Francisco who experienced an episode of "going crazy" just before her scheduled departure for Nicaragua. Her husband of 23 years had left her 3 weeks prior to her episode, taking all of the money that they had saved for their retirement, and took his new 21-year-old girlfriend of 6 months to the Santiagos' dream retirement home in Nicaragua. The week before her episode, her husband had asked her to come to Nicaragua to be with him, to take care of him, and to live with him and his new girlfriend because "she took care of him the best." She bought herself an airplane ticket and made plans to join him before her episode, despite her 23-year-old daughter's advice to stay in the United States. The day of her scheduled flight to Nicaragua, she "lost it" and was rolling on the bed, banging her head against the wall, screaming and crying, and yelling at everyone to leave her alone. She did not recall all of the events leading to her hospitalization. Her daughter called 911, and she was taken by ambulance to the hospital, was evaluated, and later was released. She noted that prior to her attack, she was distracted and had racing thoughts, had lost 5 pounds as a result of a loss of appetite, and complained of feeling angry with her second husband. Mr. Santiago was described as an alcoholic and a womanizer (*mujeriego*), both of which Mrs. Santiago had tolerated. He had both physically and verbally abused her, telling her that she was "fat, ugly,"

and that he was “tired of her,” but she had not told anyone of these events because she was afraid of what people would say.

Video 5–1 is a good example of how to explore with a patient the concept of his or her illness. Dr. Boehnlein follows a similar outline as described in supplementary module 1, asking about illness models seen in others, as well as Mrs. Santiago’s impression of what can be done about it.



Video Illustration 5–1: Cultural concepts of distress—*ataque de nervios* (3:06)

Finally, it is important to note that many people feel that mental illness is greatly stigmatized. Clinicians should emphasize to patients that seeking help does not mean that they are “crazy” (Lewis-Fernández and Díaz 2002).

Examples of Specific Cultural Concepts of Distress and Idioms of Distress

Many cultural concepts of distress and idioms of distress exist across and within cultural distinctions. Some are presented in Tables 2–2 through 2–6, and many are listed in more than one table or glossary. See Appendix 2, “DSM-5 Glossary of Cultural Concepts of Distress,” for definitions.

Psychosocial Stressors and Cultural Features of Vulnerability and Resilience

When assessing the psychosocial environment, the clinician should direct his or her inquiry in widening social circles. Begin with the individual and then move out to the *partner*, the *family* (including extended family), and the *community*. It is particularly important to move beyond the nuclear family for patients from communal cultures. With each social sphere, assess for *stressors* and *supports*.

Table 2–2. Culture-bound syndromes (cultural concepts of distress) in Asia

Cultural group	Syndrome
China	<i>Qi-gong</i> <i>Shenjing shuairuo</i> Neurasthenia <i>Shen-k'uei</i>
Japan	<i>Taijin kyofusho</i> <i>Shinkei-suijaku</i>
Korea	<i>Hwa byung</i> <i>Shin-byung</i>
India	<i>Dhat</i> syndrome (also similar to <i>sukra prameha</i> [Sri Lanka] and <i>shen-k'uei</i> [China])
Malaysia	<i>Amok</i> (also similar experiences found in the Philippines, Laos, Puerto Rico, and Polynesia and among the Navajo) <i>Koro</i> (also similar phenomena in parts of South and East Asia) <i>Latah</i> (also in other parts of Asia)

Source. American Psychiatric Association 2000; Henderson and Nguyen 2004; Kaplan and Sadock 1998.

Stressors

It is useful to begin thinking about the types of stressors that were formerly included in DSM-IV-TR Axis IV, the psychosocial and environmental problems axis (American Psychiatric Association 2000). In DSM-5, these stressors are coded according to International Classification of Diseases ICD-9-CM V and ICD-10-CM Z codes (American Psychiatric Association 2013). These stressors typically include interpersonal, familial, economic, occupational, educational, or legal difficulties. To be able to assess how distressed an individual might be by the stressors that he or she faces, it is also important to examine context. The patient's context can either mitigate or exacerbate the effect of stressors (Harvey 1996). Aspects of context that may exacerbate problems include difficulties with acculturation and discrimination. Difficulty with sys-

Table 2–3. Culture-bound syndromes (cultural concepts of distress) in Latin America

Cultural group	Syndrome
General	<i>Locura</i> and <i>nervios</i> (also among Latinos in the United States) <i>Bilis</i> (also known as <i>muina</i> or <i>cólera</i>)
Puerto Rico	<i>Ataque de nervios</i> (also in Latin American and Mediterranean areas)
Mexico	<i>Susto</i> (also in Latino groups in the United States, Central America, and South America) <i>Empacho</i> (also in Cuba)
Nicaragua	<i>Grisi siknis</i> (noted among the Miskito group)

Source. American Psychiatric Association 2000; Henderson and Nguyen 2004; Kaplan and Sackdock 1998.

tems (educational, health care, legal) and discord with representatives from these systems (teachers, counselors, social workers, physicians, lawyers) can be exacerbating factors. The context may also be resource poor and unable to provide sufficient buffering such as a sparse network of social supports or a lack of community resources.

Culturally Related Strengths and Supports

- Individual-based culturally related strengths and supports include pride in one’s culture, religious faith or spirituality, artistic abilities, bilingual and multilingual skills, group-specific social skills, a sense of humor, culturally related knowledge and practical skills, culture-specific social skills, culture-specific beliefs that help one cope, a respectful attitude toward the natural environment, commitment to helping one’s own group, and wisdom from experience.
- Family and community-based culturally related strengths and supports include extended families, including non-blood-related kin; cultural or group-specific networks; religious communities; traditional celebrations and rituals; recreational playful activities; storytelling activities that make

Table 2–4. Culture-bound syndromes (cultural concepts of distress) in industrialized countries

Cultural group	Syndrome
General	Anorexia nervosa and other eating disorders (particularly in North America)
Germany	Involuntional paraphrenia (also in Spain)
United States	Spells (in the southern United States)
Mediterranean	<i>Mal de ojo</i> (also in some Latin American countries)

Source. American Psychiatric Association 2000; Henderson and Nguyen 2004; Kaplan and Sack 1998.

meaning and pass on the history of the group; and involvement in political or social action groups.

- Environmentally based culturally related strengths and supports include an altar in one's home or room to honor deceased family members and ancestors, a space for prayer and meditation, foods related to cultural preferences (cooking and eating), pets, a gardening area, and access to outdoors for subsistence or recreation (Hayes 2008).

The following is a basic schema for assessing psychosocial environment and functioning that can be further elaborated on according to the particular circumstances of your patient.

General questions

- What are the major sources of support in your life?
- What are the major stressors in your life?

Partner

- **Support:** Is your partner a source of support for you?
- **Stressors** (domestic violence): Does your partner make you feel bad about yourself? Have you been hit, kicked, punched, or otherwise physically hurt by someone in the past year? If so, by whom (Feldhaus et al. 1997)?

Table 2–5. Culture-bound syndromes (cultural concepts of distress) in Africa and the Caribbean

Cultural group	Syndrome
General (Caribbean)	Falling out (also in southern United States) Rootwork (also in southern African American and European American populations)
Sub-Saharan groups	Sleep paralysis (<i>amafufunyana</i> in Zulu in southern Africa)
Trinidad	<i>Tabanka</i>
Haiti	<i>Boufée delirante</i> (also in West Africa and France) Fright illness in native West Indians (also in Africa and Brazil)
West Africa	Brain fag
North Africa	<i>Zaar</i> (also in the Middle East)

Source. American Psychiatric Association 2000; Henderson and Nguyen 2004; Kaplan and Sack 1998.

Points to note: When exploring the relationship with the partner, it is important to screen for domestic violence because one in eight cohabiting relationships is violent (Council on Scientific Affairs, American Medical Association 1992). Because many women do not self-identify as abused, it is better to describe the specific behaviors that would constitute abuse. These questions about physical abuse will detect between 64% and 71% of abuse, including abuse by previous partners or other family members.

Family

- **Support:** Which family members are major sources of support for you? Are any family members you are close to still in your home country?
- **Stressors:** What are some of the family problems that affect you? What are some of the family conflicts you’ve been having since moving to the United States?

Table 2–6. Culture-bound syndromes (cultural concepts of distress) among Native Americans

Cultural group	Syndrome
General	Ghost sickness
Mohave	<i>Hi-wa itck</i>
Algonkian	<i>Windigo</i>
Eskimo (Arctic and Subarctic)	<i>Pibloktoq</i>
Inuit	<i>Uqamairineq</i>

Source. American Psychiatric Association 2000; Henderson and Nguyen 2004; Kaplan and Saddock 1998.

Point to note: Particularly in immigrant families, each family member may be at a different level of acculturation, with correspondingly different values, expectations, and behaviors; this can be a significant source of stress for the family.

Community

- **Support:** Is it important to you to find a community that fits with your cultural background (Barrett 2005)? If so, have you been able to find it? Is it a major source of support? Does it meet your needs?

Point to note: The clinician may also have developed a sense of whether or not the patient is part of a cultural community from the acculturation assessment earlier.

- **Stressors:** Have you and your family felt accepted in this country? Why or why not? How respected are your values and traditions by mainstream society (Barrett 2005)? Are you having other problems at work or in the community? Do you feel that you are discriminated against in the community or at work?

Points to note: This last question is purposely broad to include racial, religious, gender-based, and sexual identity–based discrimination. The patient’s awareness of racism is tied to the level of racial identity development and may be related to the level of accultura-

tion. Also, his or her ability to cope with the stress of discrimination will be improved if he or she has found a community that is supportive of his or her cultural identity.

Questions 6 and 7 from the CFI ask about patient stressors and supports (“6. Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others?” “7. Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with money, or family problems?”) (American Psychiatric Association 2013). CFI supplementary module 3, “Social Network,” and module 4, “Psychosocial Stressors,” attempt to assess these issues further (see Appendix 1).

Religion/Spirituality

- Are you a religious person?

Point to note: Screen for whether religion is important in your patient’s life (see section “Cultural Identity of the Individual” earlier in this chapter). If not, you do not need to perform the remainder of the spiritual assessment (Kehoe 1997; Richards and Bergin 1997).

Spiritual Assessment Mnemonic

The mnemonic “A HOLY” represents the following concepts in a patient’s religious or spiritual life: **A**ctive involvement, **H**urt caused by religious or spiritual influences, resources that help **O**vercome the problem, help from a spiritual **L**eader, and religious beliefs when **Y**oung.

- Are you **actively** involved in your religion, currently?

Points to note: Understanding how and why the patient is involved in his or her religion will help the clinician determine whether the patient has an *intrinsic orientation* (internalized and lived beliefs regardless of consequences), which is associated with improved mental health, or an *extrinsic orientation* (using religion as a means of obtaining status, security, self-justification, or sociability), which is associated with increased anxiety and difficulties with social and emotional adjustment.

- Do you believe that religious or spiritual influences have **hurt** you or contribute to your problem?

Points to note: Incongruence between spiritual values and lifestyle can be a source of guilt and anxiety. Patients may believe that their problems have a spiritual source. Although patients may not feel comfortable divulging this to the clinician, a representative of the Western scientific model, clinicians may be able to get a sense of their beliefs and practices by speaking to the family.

- Are there religious or spiritual resources that could help you **overcome** your problem?

Points to note: Patients may have a self-directing, deferring, or collaborative problem-solving relationship with God or with their faith. This pattern may affect how they interact with the person who is treating them.

- Would it be helpful if we consulted a religious **leader** or a traditional healer?

Points to note: Religious patients who have lost a sense of a positive spiritual identity and no longer feel that they have divine worth or potential may benefit from interventions such as counsel from a spiritual leader to help them reconnect with their spiritual identity and worth. At times, religion can have a negative effect because patients may have a misunderstanding of the doctrines of their religion (they may not have critically examined understandings they developed as children).

- What were your religious beliefs when you were **young**?

Points to note: Often the patient's core spiritual belief system was formed during childhood. As mentioned earlier, CFI supplementary module 5, "Spirituality, Religion, and Moral Traditions," and its 16 questions would be helpful in further elaborating the role of religion in the patient's life and presenting issue.

Functioning

- Each community has certain images of a successful person. Would your community judge you to be successful or unsuccessful (Berg-Cross and Chinen 1995)?

- Before you came to this country, would your community have judged you to be successful or unsuccessful?

Points to note: It can be difficult to assess functioning when you do not know the norm for functioning in your patient's culture. These questions can be helpful because they harness the community's values and norms to judge functioning. It can also be helpful to consult with a cultural broker such as the interpreter. CFI supplementary module 2, "Level of Functioning," contains eight questions asking about levels of functioning in daily activities and responsibilities, family role, work, money, community and social activities, ability to enjoy life, and how these concerns bother the patient and the family (see Appendix 1).

Cultural Features of the Relationship Between the Individual and the Clinician

Taking the time to examine the interactions between the cultural identities of the clinician and those of the patient is essential when conducting the clinical interview. The following are some suggestions for gathering this information.

Prior to starting the interview, clinicians should consider the following issues about themselves:

1. Examine your own cultural background.
 - Self-reflection, awareness, and understanding of one's own personal and professional identity development are essential for maintaining objectivity with the patient.
 - Be aware of your biases and limitations of knowledge and skills that might affect the clinical encounter.
2. Consider the cultural identity of the patient compared with your cultural identity and compare similarities and differences.
3. Move from a categorical approach to an understanding of the patient's self-construal of identity. Factor in the context of the clinical encounter, assessment, and treatment that might arise from similarities and differences.

4. Maintain an ongoing assessment of the cultural elements of the relationship.
 - Factors to consider include rapport and respect, dealing with stigma and shame, empathy, verbal and nonverbal communication, transference and countertransference, and involvement with significant others and community organizations.
 - What is the history of the relationships between the patient's culture of origin and the clinician's (e.g., colonization, sociopolitical conflict, local history and conflict, racism)? What is the relationship of the patient's culture of origin to the host or adopted country? Are there any value conflicts between the clinician and the patient?
5. Be aware of the interethnic (when therapist and patient are from different ethnic backgrounds) and intraethnic (when therapist and patient share the same ethnicity) transference and countertransference issues.
 - Common interethnic transference themes include patients distrusting the authority figure (whether it be therapist or institution), being overcompliant or friendly to please the authority figure, denying cultural factors, and feeling ambivalence. Interethnic countertransference may include the clinical anthropologist syndrome of pursuing cultural differences that are not necessarily clinically relevant. Therapists may have feelings of guilt or pity toward patients of differing ethnicities, resulting in being more timid when interviewing the patient.
 - An example of intraethnic transference is overidentifying with the therapist, which may result in idealizing the patient. Conversely, minority patients may assume that they are less competent than a therapist from the dominant culture. Patients who have different levels of acculturation compared with their therapists may also feel that the therapist has "sold out" to the dominant culture. Examples of intraethnic countertransference may include overidentification, guilt from the therapist's sociocultural and economic circumstances, anger because of increased demands from the patient, and defensive distancing due to feeling too close to the patient (Comas-Días and Jacobsen 1991).

6. Consider whether you have any specific knowledge about the patient's culture or ethnic group. If not, you may need to ask a person familiar with the patient's culture, known as a *cultural broker* or *cultural consultant*.
 - Tip: The U.S. Department of State Web site (www.state.gov) has "Background Notes/Country Fact Sheets" for independent states and regions of special sovereignty. These notes include information on the history, politics, religion, and minority populations and are useful for a quick review before you see a patient from another country or culture. Another good source is *Ethnicity and Family Therapy*, third edition (McGoldrick et al. 2005).
7. Consider the patient's motivation for seeking treatment. Is the patient coming to see you of his or her own accord? Is he or she being forced to see you by his or her family? A school? A community? The law? What do you expect the patient's attitude will be when he or she sees you?

The assessment of attitudes toward medical personnel may be very helpful in a psychotherapy assessment and can be helped with a cultural consultant. Questions that the clinician might ask patients include

- What are your expectations of your doctors?
- How is mental illness viewed in your country of origin?
- Is there stigma against mentally ill people? How are they treated (institutionalized, ignored, supported by the community)?
- How are psychiatrists portrayed in the media in your country? Do you think those portrayals are accurate?
- In your country, have psychiatrists ever been used to persecute people? Have psychiatrists ever taken part in human rights abuses?
- Do you have fears about your treatment? Can you talk about them?
- Some people consider their doctors to be their equals, sometimes even their friends. Others feel that the doctors are in a position of authority, whereas others believe that physicians are beneath them. Do you feel that the medical staff is equal to you, beneath you, or above you? What about the social workers?
- Do you feel that you can speak freely with doctors? Are you comfortable telling them when you do not agree with something they say? If not, would

you be able to express these feelings to an intermediary, such as an interpreter or social worker?

- When clinicians advise something or prescribe medicines, do you feel that you must take the advice or use the medicines? Have you ever told a doctor that you would do something you didn't want to, simply because you didn't want to openly disagree with him or her? Do you feel free to ask questions about alternatives to medications?
- Before you came here, did you have any expectations about what your psychiatrist would be like (young? old? male? female?)? How do I fit or not fit with those expectations? How do you think these differences will affect our work together?
- Do you have a preference for a male or female psychiatrist or therapist? If so, why (e.g., trust, shame, more likely to understand, easier to express yourself)?
- Do you have a preference for a psychiatrist or therapist with a cultural background that is similar to yours or different, or do you think that this does not matter? Why (e.g., trust, shame, more likely to understand, easier to express yourself)?
- Would you like sessions to be conducted in your own language?
- Would sessions conducted in your own language help you feel that you were being understood properly?
- Do you ever have difficulty understanding what your therapist is saying?
- Do you feel comfortable with your therapist?

Question 16 from the CFI ("Have you been concerned about this and is there anything that we can do to provide you with the care you need?") helps to assess the relationship between the clinician and the patient. Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations (American Psychiatric Association 2013), and supplementary module 8, "Patient-Clinician Relationship," offers five questions for the patient and seven for the clinician and highlights the patient's experiences with therapy (see Appendix 1, pp. 507–509).

Overall Cultural Assessment

The overall cultural assessment entails integrating the previous four sections to inform a culturally competent differential diagnosis and culturally congruent treatment plan. Therefore, we must have an adequate description of the patient's cultural identity, cultural explanations of his or her illness, and stressors and supports and must understand the relationship between the clinician and the patient. Factors such as the role of family members, ethnic community, cultural identity, and religious institutions should be integrated into the formulation. The experiences of immigration, acculturation, and discrimination may be relevant. Understanding the patient's expectations about outcome of treatment is often helpful in negotiating a treatment plan.

Differential Diagnosis

What is psychopathological and what is cultural? Do you feel comfortable with your knowledge of the normative practices and values of the patient's culture?

Conduct, adjustment, anxiety, mood, somatic symptom, dissociative, personality, and persistent depressive disorders are most likely to present differently across cultures (Kleinman 1988), whereas psychotic, bipolar, and substance use disorders vary less across cultures; the content and clinical relevance are culturally determined (Johnson 1988). For instance, some cultures believe that hearing the voice of a lost loved one is a natural rite of the mourning process. Be aware that a delusion by definition must be incongruent with culturally held values. The clinician is advised to read the narrative introductions to each section of DSM-5 and look for the sections titled "Culture-Related Diagnostic Issues" or "Gender-Related Diagnostic Issues" and determine whether any of these features apply to the patient. Also, consider "Conditions for Further Study" as a source of other more appropriate diagnoses, such as an acculturation problem, a religious or spiritual problem, or an identity problem.

During this part of the OCF, using a cultural consultant is critical (Lu et al. 1995). As a physician, one's social contacts are more likely to come from more privileged and upper-class backgrounds and may not be representative of the patient's cultural experience.

Formulation of a Narrative of the Patient's Case Incorporating Cultural Factors

When putting together the patient's story, bring in the patient's cultural perspective, explanatory model, and mental health concept. The clinical narrative should reflect the patient's worldview, model of causality and illness, and expectations. The central factor in establishing a therapeutic alliance is making the patient feel understood. The degree to which you understand the historical, political, and environmental factors may reflect the degree to which you empathize with the patient.

How Does the Cultural Formulation Affect Management?

The type of treatment recommended for the patient should be congruent with the patient's cultural experience. A large percentage of patients are nonadherent to their medications. Possible explanations for nonadherence may include a non-biologically based explanatory model for symptoms, mistrust of medical institutions and authorities, fear of side effects, and resistance to addressing interpsychic conflicts.

Psychotherapeutic approaches should also be selected to fit the patient's needs. People who come from collectivist cultures may not be as amenable to individual psychotherapy and may be more receptive to family therapy and involvement of individuals outside their immediate family. Conversely, people who come from societies that value individualism and autonomy may benefit more from more expressive psychodynamic psychotherapy.

Culture affects choice of medications as well (Gaw 2001). Clinicians may choose a medication that has a combination of effects to avoid giving patients "too many" pills. The clinician must prepare the patient for side effects and the duration of therapy. Many patients believe that the medications are very powerful and work immediately. Therefore, they will take only half of the prescribed dose. Having the patient bring in his or her pill bottles and checking drug levels are useful strategies. Finally, the adage "start low, go slow" warns the clinician of differing rates of metabolism and that some minority patients may lack an enzyme and therefore do not metabolize medications as well as white patients do.

Culture also affects the patient's social system, which often includes extended family and religious groups and their leaders. Part of the treatment

plan must involve the family and religious groups if appropriate. Appropriate interventions include holding family meetings, gathering collateral history, and asking patients to seek support from their church. Not involving all parts of the patient's social system can derail the treatment plan by giving the patient mixed messages about his or her treatment.

To ensure that you have provided comprehensive and culturally competent care, you may consider this useful mnemonic: **LEARN**—Listen with sympathy, Explain your perceptions of the problem, Acknowledge and discuss differences and similarities in explanation of illness, Recommend treatment, and Negotiate treatment. The first part is good for developing the therapeutic alliance, and the last four parts of the mnemonic pertain to the “overall cultural assessment” section of the OCF. By summarizing the patient's story at the end of the interview, you can convey to the patient that you understand his or her situation, note the differences between the patient's beliefs and your beliefs, and then act as a bridge between the differing belief systems to negotiate an acceptable treatment plan. Only then can you be satisfied that you have used the DSM-5 OCF to its fullest advantage as well as the sample questions from the CFI and its supplementary modules. Of course, the formulation will evolve over time as you see the patient more often, but it offers a helpful framework for beginning to understand patients from culturally diverse backgrounds that might differ from your own background.

References

- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000
- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Washington, DC, American Psychiatric Association, 2013
- Barrett KH: Guidelines and suggestions for conducting successful cross-cultural evaluations for the courts, in *Race, Culture, Psychology & Law*. Edited by Barrett KH, George WH. Thousand Oaks, CA, Sage, 2005, pp 107–123
- Berg-Cross L, Chinen RT: Multicultural training models and the Person-in-Culture Interview, in *Handbook of Multicultural Counseling*. Edited by Ponterotto JG, Casas JM, Suzuki LA, et al. Thousand Oaks, CA, Sage, 1995, pp 344–356

- Comas-Díaz L, Jacobsen FM: Ethnocultural transference and countertransference in the therapeutic dyad. *Am J Orthopsychiatry* 61(3):392–402, 1991
- Council on Scientific Affairs, American Medical Association: Violence against women: relevance for medical practitioners. *JAMA* 267:3184–3189, 1992
- Feldhaus KM, Koziol-McLain J, Amsbury HL, et al: Accuracy of 3 brief screening questions for detecting partner violence in the emergency department. *JAMA* 277(17):1357–1361, 1997
- Gaw A: Cultural context of nonadherence to psychotropic medications in psychiatric patients, in *Cross-Cultural Psychiatry*. Edited by Gaw A. Washington, DC, American Psychiatric Publishing, 2001, pp 141–164
- Guarnaccia PJ, Rogler LH: Research on culture-bound syndromes: new directions. *Am J Psychiatry* 156(9):1322–1327, 1999
- Harvey MR: An ecological view of psychological trauma and trauma recovery. *J Trauma Stress* 9(1):3–23, 1996
- Hayes PA: *Addressing Cultural Complexities in Practice*, 2nd Edition: Assessment, Diagnosis, and Therapy. Washington, DC, American Psychological Association, 2008
- Henderson DC, Nguyen DD: Culture and psychiatry, in *Massachusetts General Hospital: Psychiatry Update and Board Preparation*, 2nd Edition. Edited by Stern TA, Herman JB. New York, McGraw-Hill, 2004, pp 551–561
- Johnson FA: Contributions of anthropology in psychiatry, in *Review of Psychiatry*, 2nd Edition. Edited by Goldman H. Norwalk, CT, Appleton & Lange, 1988, pp 167–181
- Kaplan HI, Sadock BJ: *Synopsis of Psychiatry*, 8th Edition. Baltimore, MD, Lippincott Williams & Wilkins, 1998
- Kehoe N: *Religious/Spiritual History Questionnaire*. Cambridge, MA, Harvard University Press, 1997
- Kleinman A: *Rethinking Psychiatry*. New York, Free Press, 1988
- Kleinman A, Eisenberg L, Good B: Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. *Ann Intern Med* 88(2):251–258, 1978
- Koenig HG: *Spirituality in Patient Care: Why, How, When and What*, 3rd Edition. West Conshohocken, PA, Templeton, 2013
- Lewis-Fernández R, Díaz N: The cultural formulation: a method for assessing cultural factors affecting the clinical encounter. *Psychiatr Q* 73(4):271–295, 2002
- Lu FG: *Cultural Assessment in Clinical Psychiatry: DSM-IV-TR Outline for Cultural Formulation (Grand Rounds)*. New Haven, CT, Yale Medical School, June 3, 2005

- Lu FG, Lim RF, Mezzich JE: Issues in the assessment and diagnosis of culturally diverse individuals, in *American Psychiatric Press Review of Psychiatry*, Vol 14. Edited by Oldham J, Riba M. Washington, DC, American Psychiatric Press, 1995, pp 477–510
- McGill University, Division of Social and Transcultural Psychiatry: Report on the Evaluation of a Cultural Consultation Service in Mental Health. Montreal, QC, Canada, McGill University, 2000. Available at: <http://www.mcgill.ca/tcpsych/publications/report/>. Accessed October 2, 2005.
- McGoldrick M, Giordano J, Garcia-Preto N: *Ethnicity and Family Therapy*, 3rd Edition. New York, Guilford, 2005
- Richards PS, Bergin AE: Religious and spiritual assessment, in *A Spiritual Strategy for Counseling and Psychotherapy*. Edited by Richards PS, Bergin AE. Washington, DC, American Psychological Association, 1997, pp 171–199
- Tseng WS: Migration, refuge, and adjustment, in *Handbook of Cultural Psychiatry*. Edited by Tseng WS. San Diego, CA, Academic Press, 2001, pp 695–718

Issues in the Assessment and Treatment of African American Patients

Tracee Burroughs-Gardner, M.D.

Annelle B. Primm, M.D., M.P.H.

William B. Lawson, M.D., Ph.D.

Deborah Cohen, M.B.A.

African Americans are a heterogeneous group who trace their ancestry to Africa. With the dispersal of African people around the world, U.S. residents with African ancestors include both those born in the United States and those who are immigrants from African countries and other nations. The overwhelming majority of African Americans are U.S.-born descendants of slaves, primarily of West African origin. Adding diversity to this group are individu-

als from Caribbean nations and Central and South America, who may also consider themselves Hispanic, as well as those from South and East Africa, who tend to be more recent immigrants.

More than half of foreign-born blacks in the United States today came from Caribbean countries, and more than one-third came from Africa (U.S. Census Bureau 2010). Collectively, they represent multiple variations in national origin, religious beliefs, and customs. Typically, the literature is imprecise in the terms used to identify people of African descent, and the terms *African American*, *black*, and *nonwhite* are often used interchangeably.

Historically, the “one-drop rule” established that anyone with any African ancestry was considered African American. Today, African Americans include those with varied appearance and considerable cultural and genetic diversity. Both societal perceptions of race and self-identification can have an impact on mental health. In this chapter, the terms *African American* and *black* are used interchangeably to encompass the wide range of people of African descent who live in the United States. This reflects the common patterns of terminology. We want to be clear that, in spite of which term may be used, we are talking about people of the African diaspora, that is, individuals of African descent throughout the globe.

Despite the diversity within the African American population, global racism and the history of people whose ancestors were from Africa inform the African American experience to a large extent. People are most often judged socially by how they appear phenotypically. This has a major impact on all aspects of the lives of African Americans, especially their mental health (Jones et al. 2008).

Approximately 42 million people (almost 14% of the population) in the United States identify themselves as African American. In 2010, for the first time, Hispanics, not African Americans, were the largest minority group in big cities—Hispanics made up 26% of primary city populations compared with 22% for African Americans (Frey 2011). According to the 2010 census, 55% of all African Americans live in the South, 18% live in the Midwest, 17% live in the Northeast, and 10% live in the West. Fifteen percent reside in rural areas, compared with 23% of whites and 25% of all Americans (U.S. Census Bureau 2011b). African Americans are underrepresented in the mental health workforce. Only 3% of psychiatrists, 2% of psychologists, and 4% of social workers identify themselves as African American (Primm and Lawson 2010).

Historical Context

The Fourteenth Amendment to the U.S. Constitution extended citizenship to African Americans and forbade states to take away civil rights. The Fifteenth Amendment prohibited disenfranchisement on the basis of race. However, the “Jim Crow” laws (or “black codes”) that were enacted in many southern states prevented African Americans from bettering themselves (National Park Service 2014). As late as 1910, 89% of all blacks lived in legalized subservience and deep poverty in the rural South (U.S. Department of Health and Human Services 2001).

Seeking jobs and greater tolerance, many African Americans migrated to northeastern and Midwestern states beginning with World War I, and after World War II, many moved to selected urban areas in the West, mostly in California (U.S. Department of Health and Human Services 2001; Wilkerson 2010).

In 1954, the U.S. Supreme Court declared racially segregated education unconstitutional, and the Civil Rights Act of 1964 prohibited both segregation in public accommodations and discrimination in education and employment. The use of voter qualification tests was suspended in 1965 with passage of the Voting Rights Act. However, voter identification requirements that were proposed and enacted during the 2012 election cycle have raised concerns for many (Underhill 2014).

The legacy of slavery and discrimination continues to influence the social and economic standing of African Americans in the United States. An example of institutional racism can be found in the old and obsolete diagnosis of *drapetomania*. This term was used to describe a disease that caused black slaves to run away from their masters. The construct was based on the theory that because blacks are by nature subservient, those who tried to escape from slavery were behaving contrary to their natural tendencies and must be ill. This “diagnosis” and others were based on racist notions of black inferiority and led to warnings that treating black slaves as equal to whites could induce illnesses such as drapetomania.

This historical context is important to understanding current mental health status. It is important to note that only very limited classic psychiatric care was available for African Americans, mostly in state hospitals established in the 1800s, and some of these hospitals were exclusively for African Amer-

icans. St. Elizabeth's Hospital, a federally funded hospital in Washington, D.C., was built by slaves and opened in 1855. It had separate wards for slaves, freedmen, and whites. Desegregation of state mental hospitals occurred in the 1960s, leading to improvement in care, and the development of community mental health centers beginning in the 1960s played an important role in expanding access. Yet the mental health needs of African Americans remain largely unmet, as is discussed later in this chapter.

Many African Americans have been able to overcome adversity and to maintain mental health because of their resilience and their ability to forge social ties. Many have shown extraordinary individual and collective strengths that have enabled them to survive and to do well, often in the face of enormous odds. Through mutual affiliation, loyalty, and resourcefulness, they have developed adaptive beliefs, traditions, and practices. For example, nearly 85% of African Americans say that religion is very important in their lives compared with 56% of Hispanics and whites (Newport 2006). Coping responses include prayer; confronting problems rather than shrinking from them; and turning to family, friends, neighbors, and community organizations for aid—a strategy that evolved from the experience of having to rely on one another, often for their very survival (U.S. Department of Health and Human Services 2001). Unfortunately, psychiatric treatment strategies were not effective for people with severe mental illness, for whom the only option was often lifelong stays in asylums until the 1950s and 1960s, when new treatments became available. Nevertheless, African Americans were often more likely than other ethnic groups to retain and keep ill members at home, supported by their family members.

Many African Americans have developed a capacity to downplay stereotypical negative judgments about their behavior and to rely on the beliefs and behavior of other African Americans as a frame of reference. They have a collective identity and perceive themselves as having a significant sphere of collectively defined interests. Such psychological and social frameworks have enabled many African Americans to overcome adversity, maintain their mental health, or cope with or overcome mental health challenges.

Current Context

Family Structure

In 2011, there were almost 10 million African American households in the United States, with an average size of 3.3 people compared with an average of 3.1 for the general population (U.S. Census Bureau 2011b). Only 38% of African American children live in two-parent families, compared with 69% of all children in the United States. About 50% of African American children live with their mother only, compared with about 20% of white children and 24% of all children (U.S. Census Bureau 2011a). African American children are more than twice as likely as white children to enter foster care and stay about 9 months longer. The main factors influencing the higher rate for African American children are their higher rates of poverty, challenges in accessing support services, racial bias against them, and difficulties in finding appropriate permanent homes, according to a federal report (Government Accountability Office 2007).

Socioeconomic Status

Census data from 2010 show that 83% of African Americans age 18 or older had earned at least a high school diploma, and 17% had received bachelor's or graduate degrees (U.S. Census Bureau 2010). In 2010 the median income of African American households was \$32,068, compared with \$54,620 for white households. The poverty rate for African Americans (27%) is more than two and a half times that for whites (10%). Moreover, African Americans have less than 10% of the family wealth as compared with other groups because most of their income comes from the last one or two generations (U.S. Census Bureau 2011c). Single white women in the prime of their working years (ages 18–64) have a median household wealth of \$41,500, whereas the median wealth for single black women in their prime working years is only \$100. Black women make up the largest group with a negative net worth (Insight Center for Community Economic Development 2012). African Americans are more likely to move in and out of poverty because they have relatively few assets to protect them when they are unemployed. Of African Americans in metropolitan ar-

eas, approximately 51% lived in the suburbs in 2010, up from 44% in 2000 (Frey 2011).

Many African Americans still live in segregated neighborhoods, and poor African Americans tend to live among other African Americans who are poor. According to a Brown University study, segregation between blacks and whites remained fairly steady between 2000 and 2010, with approximately 65% of people in metropolitan areas living in areas of high segregation between blacks and whites (Logan 2011). Poor neighborhoods tend to have few resources, a disadvantage reflected in high unemployment rates, homelessness, crime, and substance abuse. Children and youths in these neighborhoods often are exposed to violence. They are more likely to suffer the loss of a loved one, to be victimized, to attend substandard schools, to experience abuse and neglect, and to encounter too few opportunities for safe, organized recreation and other constructive outlets. Personal vulnerabilities are exacerbated by problems at the community level that are beyond the sphere of individual control.

African Americans are disproportionately represented in the criminal justice system: 5% of African American men were incarcerated in 2009 (2.6 times the rate of Hispanic men and 6 times that of white men). A Bureau of Justice study found that more than half of all inmates have mental health problems, and an estimated 7%–20% have serious mental illness (U.S. Department of Justice 2007, 2010).

On the other hand, strong African American communities, both rich and poor, possess cohesion and informal mechanisms of social control, sometimes called *collective efficacy*. Some evidence indicates that collective efficacy can counteract the effects of disabling social and economic conditions, and it has been associated with lower rates of depression and suicide, particularly among older adults (Ahern and Galea 2011). Such mechanisms may also explain why African American youths are less likely to use drugs than their white counterparts.

Physical Health Status

In general, the health status of African Americans is worse than that of whites—in 2010 infant mortality was worse, and life expectancy was 75.1 years for African Americans and 78.7 years for the general population (National Center for Health Statistics 2013). African Americans are more likely than the

general population to have comorbid conditions such as diabetes, heart disease, HIV/AIDS, hepatitis C, prostate cancer, and breast cancer. Their mortality rates from these diseases are higher than rates for other Americans, and the infant mortality rate among African Americans is more than twice that among whites. The AIDS rate among African American men is more than 7 times that of whites, and the rate for African American women is 20 times greater than that for white women (Office of Minority Health 2005). African Americans report poorer health than whites—some 56% of African Americans report their health as very good or excellent compared with 68% of whites, and 14% of African Americans report their health as fair or poor compared with 10% of whites (Centers for Disease Control and Prevention 2011). To compound this situation, African Americans are less likely to have a regular source of medical care and more likely to obtain their health care from hospital outpatient clinics and emergency departments (U.S. Department of Health and Human Services 2001).

Some research has looked at intergroup variation and the influence of nativity and immigration on health status. A study looking at self-rated health among African Americans and Caribbean blacks found that Caribbean-born blacks had the best health and U.S.-born Caribbean blacks had the worst health (Griffith et al. 2011). In general, research has shown that immigrants have worsening health status the longer they are in the United States (Miranda et al. 2008).

Mental Health Status, Use of Services, and Disparities

Historical and Sociocultural Factors

Several factors are associated with increased risk for mental disorders in African Americans, including 1) racism, discrimination, and prejudice; 2) lower socioeconomic status and related environmental stressors such as chronic exposure to violence and increased likelihood of having witnessed or been a victim of violence; 3) more comorbid medical problems; and 4) biases, stereotypes, and misperceptions held by some health care professionals and some African Americans about mental illness. Poor mental health is more common among the impoverished than among the more affluent (U.S. Department of Health and Human Services 2001).

Disorders and Prevalence

In general, rates of mental illnesses in African Americans are similar to those of the general population. However, there are differences in some specific disorders, and there are disparities in mental health care. African Americans and Hispanics experience a greater risk of a longer duration of mental illness, greater illness burden, and greater severity than do whites (Breslau et al. 2005; Kessler et al. 2005).

Depression. The National Center for Health Statistics 2005–2006 household survey showed that rates of depression in general among African Americans were higher than among whites (8.0% and 4.8%, respectively) (Pratt and Brody 2008). However, another study, with data from the National Survey of American Life, found that rates of major depression among African Americans (10%) and Afro-Caribbeans (13%) were lower than those of white Americans (18%) (Williams et al. 2007). In a study of adults age 55 years and older, African Americans had lower rates of depression and dysthymia than did Latinos, whites, or Asian Americans (Woodward et al. 2012).

Depression is often more chronic and disabling in blacks than among non-Hispanic whites (Breslau et al. 2005). There can be cultural and ethnic differences in the way the disorder is expressed. For example, African Americans with depression are more likely to report somatic complaints, insomnia or hypersomnia, and appetite changes, whereas whites are more likely to report cognitive disturbance, anxiety, and core depressive feelings (Bailey et al. 2009). Misdiagnosis may explain the lower rates in some studies. Depression in African Americans may have to be more severe to be recognized. Also, some research suggests that African Americans may use negative health approaches, such as overeating and drug abuse, as self-treatment for depression (Jackson et al. 2010).

A large national study looking at the association between the perception of racial discrimination and the lifetime prevalence rates of psychological disorders found that the perception of racial discrimination was associated with several disorders, including major depressive disorder, posttraumatic stress disorder (PTSD), and substance use disorders, among African Americans, Hispanic Americans, and Asian Americans, independent of the socioeconomic status, level of education, age, and gender of participants (Chou et al. 2012).

Anxiety. Evidence is inconclusive about prevalence rates of anxiety disorders among African Americans. The National Comorbidity Survey Replication, which used structured interviews, found lower rates of anxiety disorders in racial and ethnic minorities, including African Americans, than in non-Hispanic whites (Kessler et al. 2005). Prevalence rates based on diagnoses by clinicians invariably indicate lower rates of anxiety disorders in African Americans, although misdiagnosis may be a factor (Lawson 2002, 2007; Primm and Lawson 2010).

Looking specifically at PTSD, African Americans have a higher lifetime prevalence of PTSD (8.7%) than do Hispanics (7%), whites (7.4%), or Asian Americans (4%). Socioeconomic factors, such as greater exposure to crime and trauma in urban environments and in combat situations in the military, can play a role in the higher prevalence of some anxiety disorders, such as PTSD (Primm and Lawson 2010).

Experiencing discrimination has also been associated with increased anxiety. More frequent experiences of non-race-based discrimination predicted generalized anxiety disorder for all groups in a sample from the National Survey of American Life. Experiencing race-based discrimination was associated with significantly higher odds of generalized anxiety disorder for African Americans (Soto et al. 2011).

Schizophrenia. Compared with whites, African Americans more frequently receive the diagnosis of schizophrenia and less frequently receive the diagnosis of mood disorders (Gara et al. 2012). Differences in how African Americans express symptoms of emotional distress may contribute to misdiagnosis (Bresnahan et al. 2007; Primm and Lawson 2010). A recent study examining diagnosis of schizophrenia in African Americans found that African American patients had higher ratings of psychosis but similar ratings of mood symptoms compared with white patients. The study authors suggested that clinicians may overvalue psychotic symptoms, leading to more diagnosis of schizophrenia spectrum conditions (Gara et al. 2012). In addition, African Americans' previous discriminatory experiences may lead some to express fears and anxiety in ways interpreted as more psychotic. Also, a worldview influenced by past experience of racial discrimination resulting in healthy paranoia and cultural mistrust, cultural differences in symptom presentation, and postponed help seeking leading to greater severity of illness once the person presents for

care may contribute to African American patients presenting with higher levels of psychosis. Incorrect diagnosis of schizophrenia among African Americans can lead to adverse circumstances, including insufficient or inappropriate treatment, wrong assumptions about prognosis, and racial disparities in care (Gara et al. 2012).

Substance use disorders. A national survey found that the rates of alcohol use and binge alcohol use were lower for blacks than the national average (44% vs. 55% and 22% vs. 25%, respectively). The rate of illicit drug use among blacks was slightly higher than the national average (10% vs. 8%), although this varied by age group (Substance Abuse and Mental Health Services Administration 2010). Compared with whites, African Americans are less likely to have ever smoked, but of those who do smoke, African Americans are less likely to quit. Recent research has identified some differences in approach to quitting; for example, African Americans and other racial or ethnic minorities are less likely than whites to use nicotine replacement therapy (Trinidad et al. 2011).

Eating disorders. The prevalence rates of anorexia nervosa and binge-eating disorder are similar among African Americans and other groups, but bulimia nervosa is more prevalent among African Americans and Latinos than among non-Hispanic whites, according to research based on pooled data from the National Institute of Mental Health Collaborative Psychiatric Epidemiological Studies (Marques et al. 2011). Obesity rates are particularly high among African American women and contribute to a number of diseases such as diabetes, heart disease, and stroke. Although obesity is not a specifically defined psychiatric diagnosis, overeating and weight gain may accompany psychiatric illness or psychological distress.

Suicide. Suicide rates have long been lower among African Americans than among other racial groups. The rise in suicide rates among black adolescents during the 1990s was a wake-up call to pay greater attention to the mental health of black youths and to design suicide prevention programs for the black community. Currently, the suicide rate among young African American men is no different from that in the general population. Suicide rates among African American women and elderly men are consistently lower and suggest the benefits of the protective factors discussed previously in the section “Socioeconomic Status.”

Treatment and Service Utilization

African Americans receive less care and poorer-quality health care than do whites. According to the National Healthcare Disparities Report, blacks received worse care than whites for about 40% of health care measures, and blacks had worse access to care than did whites for one-third of core measures. Few disparities in care showed evidence of improvement in recent years, and low-income people received worse care than high-income people for about 80% of core measures (Agency for Healthcare Research and Quality 2011).

Cost is a significant factor in access to mental health care. In 2009, 17% of African Americans reported delaying or not getting medical care because of cost, and 15% reported not getting prescription medication because of cost (Centers for Disease Control and Prevention 2011). African Americans are more likely to be uninsured than are whites: 21% of African Americans and 14% of whites lack health insurance coverage (Centers for Disease Control and Prevention 2011).

The National Comorbidity Survey found that only 16% of African Americans with a diagnosable mood disorder saw a mental health specialist, and less than one-third consulted a health care provider of any kind. Blacks are less likely than whites to see a health care provider and significantly less likely to receive appropriate care than are whites, and only one in three African Americans who need mental health care receives it (Young et al. 2001).

Although 83% of individuals with probable depressive or anxiety disorders saw a health care provider, most visited primary care providers only. Of that group, only 19% received appropriate care, compared with 90% of individuals who visited mental health professionals. Appropriate treatment was less likely for men and for individuals who were black, less well educated, younger than age 30, or older than 59 (Young et al. 2001).

Blacks are less likely than whites to receive treatment for depression (Agency for Healthcare Research and Quality 2011). African Americans and other minority groups also receive less follow-up care after hospitalization for mental illness, lower rates of antidepressant medication management, and inferior care compared with whites, even with similar access to care (Medicare beneficiaries) and after adjusting for demographic variables (Virnig et al. 2004).

Among people with a depressive episode in the past year, blacks were significantly less likely to have received treatment than whites (56% vs. 70%) accord-

ing to the 2010 National Healthcare Disparities Report (Agency for Healthcare Research and Quality 2011). Older African Americans are less likely to receive a diagnosis of depression than are their white counterparts but are also less likely to get treated. Researchers using 2001–2005 data from the nationally representative Medicare Current Beneficiary Survey found that about 6.4% of whites, 4.2% of African Americans, and 7.2% of Hispanics had diagnoses of depression. Among those diagnosed, 73% of whites received treatment (with antidepressants, psychotherapy, or both), compared with 60% of African Americans and 63% of Hispanics (Akincigil et al. 2012).

African Americans are more likely to access substance use treatment through a general medical facility and less likely to access treatment through a specialty addiction treatment facility than are whites (Lo and Cheng 2011). African Americans who receive treatment for substance use disorders are significantly less likely than whites to complete treatment (Agency for Healthcare Research and Quality 2011). A study of individuals with eating disorders found that lifetime prevalence of mental health service use was lower among African Americans and other diverse ethnic and racial groups than among non-Latino whites (Marques et al. 2011).

It is quite common for African Americans to express concerns about the stigma of mental illness (American Psychiatric Association 2011). Stigma serves as a barrier to seeking treatment and contributes to the underuse of mental health services among African Americans. Other factors that serve as barriers to receipt of mental health services are dysfunctional coping behavior, shame, and denial (Primm and Lawson 2010).

Help Seeking

African Americans overall, as well as those who have diagnoses of depression, had more positive views about seeking mental health care than did their white counterparts. This seems somewhat paradoxical given that African Americans were less likely to use mental health services (Diala et al. 2002). Furthermore, compared with whites, African Americans who had used mental health services were more likely to have negative attitudes and were less likely to continue with treatment. Blacks are less likely to complete treatment for substance use disorders than are whites (Agency for Healthcare Research and Quality 2011).

Overall, African Americans have a lower likelihood of using mental health services. African Americans and other diverse groups are less likely to seek

treatment for PTSD than are whites; less than half of the nonwhite population with mental illness seek treatment (Roberts et al. 2011). African Americans are less likely to use medications than are either whites or Latinos (see Figure 3–1). Also, African Americans tend to delay seeking help for general health and mental health concerns, and delays may extend over decades (Neighbors et al. 2007). African Americans are more likely to seek help from prayer or spirituality and less likely to seek help from complementary or alternative sources than are individuals from other racial/ethnic groups (see Figure 3–2). African Americans are more likely than whites to believe that mental health problems will improve on their own, yet they are also more likely to believe that mental health professionals could help individuals with mental illness such as schizophrenia or major depression (Anglin et al. 2008).

African Americans often rely on informal sources of support for mental health concerns. A study that used data from the National Survey of American Life on African American and Caribbean black men with a lifetime mood, anxiety, or substance use disorder found that some 33% used both professional services and informal support, 14% relied on professional services only, 24% used informal support only, and 29% did not seek help. African American men were more likely than Caribbean black men to rely on informal support alone. Marital status, age, and socioeconomic status influenced help-seeking behavior. The reliance on informal support suggests that the support plays a strong protective role (Woodward et al. 2011).

Psychopharmacology

It is crucial to pay close attention to the racial and ethnic differences in responses to psychopharmacological treatment. African Americans are more likely than whites or Asians to be poor metabolizers because of genetic polymorphism of liver enzymes involved in drug metabolism. Poor metabolizing can result in high plasma levels and potentially more side effects and higher toxicity (Bradford 2005). This phenomenon can be seen with both antidepressants and antipsychotic medications. The higher sensitivity to these medications is manifested in a faster and higher rate of response and more severe side effects, including delirium, when black patients are treated with doses commonly used for whites.

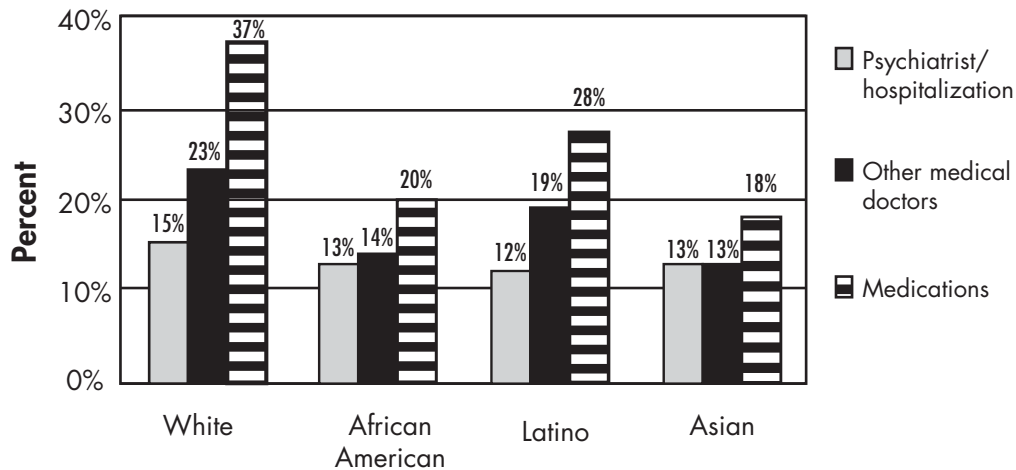


Figure 3–1. Use of mental health services by race/ethnicity.

Past 12-month service use for mental health problems for U.S. adults with any 12-month DSM-IV disorder.

Source. Sribney et al. 2010.

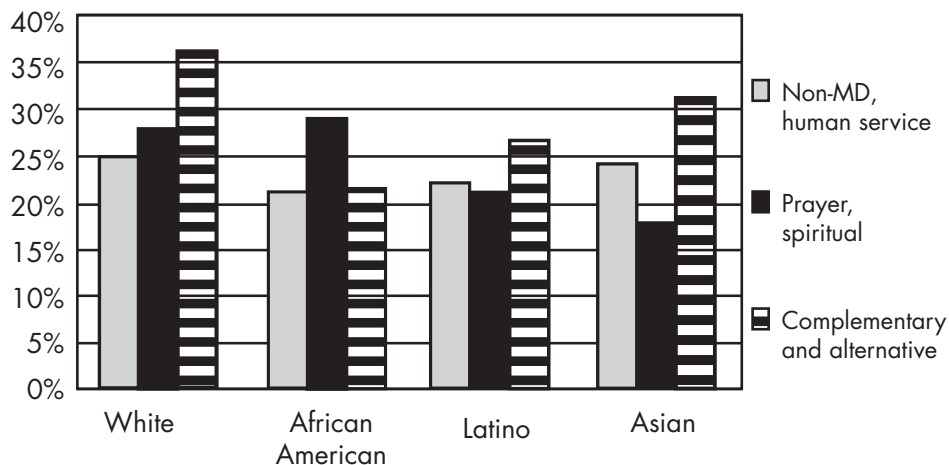


Figure 3–2. Non-M.D. service use by race.

Non-M.D., human service: Psychologists, social workers, counselors, mental health hotline, nurses, occupational therapists, other health professionals, religious or spiritual advisers, self-help groups, Internet support groups.

Prayer, spiritual: Prayer, spiritual healing, or other spiritual practices.

Complementary and alternative: Herbal therapy, homeopathy, high-dose vitamins, special diets, acupuncture, biofeedback, chiropractic, exercise or movement therapy, massage, hypnosis, imagery therapy, relaxation or meditation, energy healing, and psychic or other non-traditional remedy or therapy.

Source. Sribney et al. 2010.

This observation supports the practice of psychiatrists using lower starting doses (paying attention to adverse effects and poor adherence), slower upward titration, and plasma level monitoring in African American patients. This is particularly important given the mistrust that many African Americans feel toward mental health providers and their ambivalence about mental health services and medications.

Additional consideration should be given to the effects on medications of nutrition, diet, tobacco use, and alcohol and illicit drug consumption. Alternative and complementary therapies also can have significant effects on the metabolism of psychotropic medications (Strickland et al. 1997). See Chapter 11, “Ethnopsychopharmacology,” for more information.

Barriers to Treatment

Patients’ fears of addiction to antidepressant medications and of mental illness–associated stigma, their reliance on spiritual beliefs to cope with depression, and their concerns about trust and other aspects of relationships with health care providers are potentially important personal barriers to mental health treatment in African Americans. These issues are demonstrated in Case 1 (see Video 3–4) (Primm et al. 2002).



Video Illustration 3–4: Treatment negotiation— African American (5:51)

Physician-patient communication differs for African Americans and whites. One study found that physicians were 23% more verbally dominant and engaged in 33% less patient-centered communication with African American patients than with white patients (Johnson et al. 2004).

Applying the Updated DSM-5 Outline for Cultural Formulation

DSM-IV introduced the Outline for Cultural Formulation (OCF), which was updated in DSM-5 (American Psychiatric Association 1994, 2013) (see Table 3–1). The OCF is a useful framework for organizing information in a culturally appropriate assessment. DSM-5 also introduced the Cultural Formula-

tion Interview (CFI), which consists of 16 questions, 12 supplementary modules, and one informant module to elicit the information contained in the OCF (see Appendix 1, “DSM-5 Outline for Cultural Formulation, Cultural Formulation Interview, and Supplementary Modules”). The purpose of the CFI is to help clinicians complete a cultural formulation on all patients by providing sample questions that can be added to a standard psychiatric assessment to address cultural issues.

Cultural Identity of the Individual

Understanding the role of culture and race in concepts of identity and self is essential for quality mental health services. Racial identity and cultural identity are both necessary descriptors for use in formulations to increase the reliability of DSM-5 (American Psychiatric Association 2013) diagnoses and conceptualizations (Dana 2002).

African American racial identity is based on a collective interpretation of group experience that includes grievances about disadvantaged status and continuing power differentials. An important aspect of racial identity is racial consciousness. The spectrum of African American racial consciousness typically ranges from the militancy encompassing the psychological and sociopolitical dimensions invoked by the term *Afrocentrism* and the acquiescence to or acceptance of a European American construction of reality by African Americans. Although racial consciousness can be marginalizing, in its healthiest manifestation, it can enrich and empower individuals and endow them with meaning, dignity, history, and group integrity contained in a sense of self (Dana 2002).

Another dimension of cultural identity is defined by societal views. For African Americans, racial identity often triggers negative responses from others. First described by psychiatrist Chester Pierce, M.D., *microinsults* and *microaggressions* refer to the frequent slights experienced by African Americans in everyday life (Pierce 1970). African Americans’ difficulties in getting a taxi, being approached intrusively and followed by salespeople in commercial establishments, and being denied basic courtesies by whites are all examples of microinsults or microaggressions. These examples may be regarded at first glance as random acts of impoliteness, but the cumulative effect of such slights over time reinforces the message to black people that they are devalued, do not

Table 3–1. DSM-IV-TR Outline for Cultural Formulation (OCF) and updated DSM-5 OCF

Cultural identity of the individual

Cultural explanations of the individual's illness
(Cultural concepts of distress)

Cultural factors related to psychosocial environment and levels of functioning
(Psychosocial stressors and cultural features of vulnerability and resilience)

Cultural *elements* (features) of the relationship between the individual and the clinician

Overall cultural assessment *for diagnosis and care*

Note. Updates are in parentheses; deletions are in italics.

Source. American Psychiatric Association 1994, 2013.

deserve the respect of whites, and may be suspected of being criminals. Such repeated treatment and cumulative affronts fuel anger, resentment, low self-esteem, and poor mental health and well-being (Mercer et al. 2011).

A particularly egregious form of microaggression is the police policy of “stop and frisk” and its disproportionately large impact on the African American community, especially young males. Recent publications and editorials have focused on how the War on Drugs has resulted in the targeting and racial profiling of young black males who are presumed to be in possession of illegal drugs (Alexander 2010; Krugman 2012). The high frequency of occurrences wherein young black males are stopped and frisked has led to great angst among young people and fear that they will be arrested, detained, or even imprisoned without cause. These aggressive police actions are having a negative effect on the psyche of young black people, causing them to fear and distrust the police and be mired in despair.

Recent research by Camara Jones, M.D., demonstrated how socially assigned race (i.e., the race that society would assume an individual is by looking at his or her phenotype) determines how individuals are treated and affects their sense of well-being. She found that people with socially assigned black or Hispanic race or ethnicity were significantly more likely to perceive their health and well-being as poor (Jones et al. 2008).

When working with persons who appear “black,” it is important to understand the person’s family of origin. Having patients describe their heritage and cultural background, and those of their parents and grandparents, is important in order to have a context for understanding their behavior, defenses, expectations, vulnerabilities, and emotions. The clinician should explore whether the patient prefers to be referred to as black or African American. The latter term is less stigmatizing to some because it includes reference to cultural heritage and formalizes the African connection.

Case 1 (Video 3)

Mr. Jones is a 32-year-old married African American man who is a computer network administrator for San Francisco State University. His wife, Tina, is an African American lawyer working at her father’s firm. Mr. Jones presents because a few weeks ago he forgot to pick up his daughter from day care because he was too tired. “I’m not acting like myself,” he states. He describes his life as being “Mr. Mom.” He has been feeling this way for at least a year, but he has felt worse in the last few months. His wife asked him to get help, and he asked her to make the appointment for him. He complains of fatigue and irritability and of people, including his supervisor, “buggin’ me” to get his work done on time. He states that his wife is a workaholic and that it is his job to pick up their 2-year-old daughter, Brittany, from day care because of his wife’s unavailability during her 10- to 12-hour workdays. Her work schedule has significantly affected their relationship, and they rarely have sexual relations. They argue frequently. He complains of early-morning awakening, alternating with days when he has difficulty waking up.

CFI supplementary module 6, “Cultural Identity,” can be helpful here, as it has 34 questions that can help to conceptualize the individual’s cultural identity. Questions 5 and 6 are particularly helpful in assessing cultural identity in African Americans: “5. Which part of your background do you feel closest to? Sometimes this varies, depending on what aspect of your life we are talking about. What about at home? Or at work? Or with friends?” “6. Do you experience any difficulties related to your background, such as discrimination, stereotyping, or being misunderstood?” This could have been explored further by Dr. Boehnlein with Mr. Jones in Video 3–1. In the video, Dr. Boehnlein asks Mr. Jones to talk about what it was like growing up. Mr. Jones speaks of not being able to relate to his friends from East Oakland anymore, but he also does not feel connected to his wife’s family, as is seen later in the interview.

Video Illustration 3–1: Cultural identity—African American (4:13)

The assessment of the role of religion can be important for many patients and should be done with African American patients. Supplementary module 5 of the CFI, “Spirituality, Religion, and Moral Traditions,” with its 16 questions, is a good starting point for assessing the role of religion in a patient’s cultural identity, stressors and supports, and social network. The first question, “1. Do you identify with any particular spiritual, religious or moral tradition? Can you tell me more about that?,” is similar to Dr. Boehnlein’s questions in Video 3–2 as he asks Mr. Jones to talk about the role that religion played in his life as a young man and the role it plays in his life today, as a father and husband. Note how Dr. Boehnlein assesses the beliefs and practices of both Mr. Jones and his wife and how they have brokered a compromise between Baptist and Catholic beliefs.

Video Illustration 3–2: Spiritual assessment (2:37)

Case 2

Ms. S. is a dark-skinned African American woman in her 40s who grew up in a large family in an urban setting. The skin color of people in her family is like a rainbow, ranging from people who are very fair and light-skinned, who could pass for white, to those with “caramel complexions” and those described as “dark as a skillet.” Ms. S. is on the darker end of the spectrum. As a child, her family members and schoolmates ridiculed her because of her dark skin color. Her short, tightly curled hair was often compared with that of her siblings, which was long and wavy. “Why couldn’t you have ‘good’ hair, like so-and-so?” was a frequent question. She also couldn’t help but notice the favoritism with which her lighter-skinned siblings were treated. This was a source of hurt and gave her the sense of being alienated from her own flesh and blood.

Although she embraced her racial identity as an African American, much of the time she felt that her skin color was some sort of dark prison that put her at others’ mercy. It felt like a badge of shame. Her skin color “preceded” her in public. When shopping, she would be watched like a hawk, as if the salespeople thought she would steal something. She longed to have a romantic relationship with a man but felt passed over by men who preferred women with more white features. She read somewhere that as a black woman of her age, she was more likely to be murdered than to find a marriage partner. In this re-

gard, she felt that her skin pigmentation placed her at an extreme disadvantage. At times, she wished she were white, or at least light-skinned, because she thought that would make her life so much easier. When she thought that way, she felt very guilty, especially when she thought about the sacrifices her ancestors had made during slavery and those of freedom fighters in the Civil Rights Movement. This mix of feelings—of not belonging, of not melting in the so-called melting pot, of being rejected by her family and society, and of having guilt about wishing she were of another race—left her in a no-man's land. These feelings generated a chronic, smoldering depression that eventually drove her to seek help from a psychiatrist.

A documentary film, *Dark Girls*, incorporates interviews of dark-hued African American women who describe how they were discriminated against by their own people, including their family members, because of the color of their skin (Duke and Berry 2011). They recount being bullied as children and humiliated by comments, even as adults, claiming that they were unattractive, undesirable, and unintelligent because of their dark skin. These examples of intraracism or colorism have a negative psychological effect and have led some women to use bleaching cream to make their faces lighter, sometimes at the expense of their health. In this case, the goal of approximating white or light skin supersedes concern about health risks associated with the use of harsh chemical products (Berry 2009).

It is important to explore the level of acculturation or assimilation in African Americans. An Afrocentric worldview acknowledges concepts of groupness, sameness, and commonality and includes values and customs relevant to cooperation, collective responsibility, and interdependence. Some African Americans have a bicultural perspective, understanding the “rules” for good functioning in both African American and white social contexts, although they may be more comfortable in one milieu or the other. Some African Americans have assimilated to the point that they are more comfortable in the Anglo-American world (Dana 2002).

The *internalization of racism*—the internalization of negative stereotypes of black people—is exemplified by the research of Drs. Kenneth and Mamie Clark in the 1940s in which they presented black and white dolls to black children for them to choose which one they would like to play with, which one was nice, which one had a nice color, and which one looked bad. The experiment found that black children, influenced by their socialization even as early

as 3 years old, chose the white doll as being nice, having nice color, and being the one that they would prefer to play with. In contrast, the black doll was identified as being bad. These choices reflect the internalization of the negative stereotypes of dark skin color, which sets the stage for psychologically destructive self-loathing. A recent replication of the Clarks' experiment (CNN 2010) had similar results. This suggests that despite some progress over the past 50 years, the impact of negative stereotypes on identity and self-worth of children remains tenacious. The potential for transgenerational transmission of these beliefs is high, and the consequences to self-concept and achievement are grave.

Case 1 (continued)

Acculturation and assimilation play a large role in the case of Mr. Jones. Although he is still living in the same state in which he was born, he is essentially living in a different world with a different set of rules, norms, and values, which he is attempting to navigate. Mr. Jones was raised in a working-class African American neighborhood in East Oakland, California, which had some degree of crime and drug use. He is currently living, presumably, in an upper middle class neighborhood in a home gifted by his father-in-law. He and his wife appear to have differing ideas of priorities at this point in life. In addition, it appears that he is struggling to some degree with his role as the man in his home relative to the things his wife's family is providing (e.g., house, country club membership). There is likely some question about his role and position and how he fits into this upper middle class community, especially as he works to reconcile his two worlds. This is reflected in the physical bridge that he has to cross to visit the church of his childhood, which helps him maintain spiritual grounding. He is experiencing almost a sense of alienation in that he feels that he is a househusband, fulfilling the role of the female gender, which emasculates him. Although this may not be an issue of assimilation or acculturation in the traditional sense, it is one that many African Americans with similar backgrounds face. In Video 3–3, note how Dr. Boehnlein assesses how Mr. Jones is at odds with his core support system.



Video Illustration 3–3: Role of the community (5:09)

Another class/race interaction or conflict has been referred to as “the first Negro up the greasy pole.” This refers to the first African American to accomplish a major feat or to be appointed to or elected to a high-profile position of

responsibility or authority. Although this type of accomplishment is something to celebrate and serves as an inspiration to others, there is the recognition that holding the position as the first black person to do so is fraught with perils such as being held to a higher standard, excessive scrutiny, criticism, and even sabotage, not only from people of European descent but also, at times, from African Americans. The metaphor of the “greasy pole” signifies how hard it is to climb the ladder of success as a black person and how easy it is to slip downward as a result of the negative pressures. President Obama is an example of this phenomenon.

For many, being the first black person in a high position creates a sense of isolation from other blacks because in settings such as corporate America, few blacks are in top-level positions. Black people outside of this realm may criticize blacks at the top as “acting white” and forgetting where they came from. Compounding this challenge is also an accompanying sense of alienation from whites who may not believe a black person deserves or is truly qualified to hold a position of superiority over whites in a given organization. The psychological costs of being the first black person in a position of leadership are potentially great, leading some to cope by overcompensating to identify with whites in order to fit in. This creates a virtual “no-man’s land” where the person feels suspect in the black community and simultaneously does not feel accepted in the white community. See Video 3–5 for a discussion of Mr. Jones’s cultural identity by Dr. Boehnlein and Dr. Lim, describing how Mr. Jones feels disconnected from his past and his current family situation.



Video Illustration 3–5: Cultural identity of the individual (3:48)

A book titled *Flash of the Spirit* (Thompson 1984) captures the essence of black culture. It describes the African American tendency to be expressive and vocal instead of quiet, decorative instead of minimalist, colorful instead of plain, and creative instead of rote or routine. This tendency, apparent in black cultural expression in music, art, fashion, and personal communication style, may underlie the influences of black music and fashion trends on national style.

Cultural Conceptualizations of Distress

Individual's Illness

The second part of the DSM-5 OCF addresses the importance of understanding the individual's, and his or her family's, conceptualization of the illness and its causes. A culturally influenced explanation can be as simple as looking at the individual's personal thoughts on his or her symptoms or as complex as exploring the possibility of the presence of cultural concepts of distress (formerly known as a *culture-bound syndrome*) (American Psychiatric Association 2013).

Culturally based and religious-based explanatory models can affect the conception of mental illness as well as help seeking and mental health service use. Religion and spirituality play a central role in the lives of many people of African descent. Many believe that worship and prayer are central to maintaining health and balance and that not engaging in religious activity is a recipe for ill health. Often, African Americans with mental illness rely on faith-based solutions to their mental health problems, to the exclusion of professional sources of help.

Some African Americans believe that mental illness results from discordant relations between a person and his or her social world. Beliefs in sorcery and magico-spiritual practices are found among many cultures from the African diaspora. These beliefs in supernatural powers and healing practices include such things as “duppies” (a Caribbean form of ghosts), obeah (traditional healing), voodoo (practiced by people of Haitian descent), hoodoo or rootwork (practiced by African Americans primarily in the South), and *santería* (a Cuban syncretism of ritual sacrifice of animals and worship of multiple African deities) and *espiritismo* (practiced by people from Puerto Rico). Given that belief in these supernatural powers and practices is accepted among some subgroups, the beliefs should not be regarded as evidence of psychosis but rather should be understood as a way in which illness is explained within a cultural context.

Case 3

Mr. B. is a 26-year-old man who was born and raised in Jamaica and migrated to the United States as an adult. He and his family are extremely religious, and his mother, with whom he lives, is studying to be a minister. He earns his liv-

ing as a truck driver and prides himself on a new rig he just bought. Things were going well with him until he began to have trouble sleeping, racing thoughts, auditory hallucinations, and feelings of suspiciousness toward others around him, including his family. These experiences were out of keeping for him, and his family noticed the change in his behavior. He began drinking excessively and at one point was charged with driving while intoxicated. Mr. B. was devastated when he lost his license to drive, which forced him to stop working as a truck driver. His mother helped him make ends meet once he no longer had a source of income. However, she blamed his predicament on his not attending church, losing his faith, and not praying hard enough. She believed strongly that his strange behavior and his misfortune were a result of his "not living right" in God's eyes. According to his mother, he would achieve reversal of his circumstances if he would start praying and return to church.

Mr. B., on the other hand, had a different explanation for his troubles and a different method for curing them. He believed that someone from Jamaica who didn't like him had placed a curse on him. When he heard voices, he felt that ghosts, or "duppies," were visiting him. He wanted to find an obeah woman to help him remove the curse. When he discovered that none were available in the area where he lived, he despaired. After he had been out of work for a while, his mother could not stand his acting strangely and cleaning the house all day and decided to take him to a mental health center for evaluation. Initially, he was reluctant to accept mental health services, but he later relented when he realized that he would not be able to visit a healer. On the basis of the evaluating psychiatrist's pathological interpretation of his beliefs in ghosts, Mr. B. was given a schizophrenia diagnosis, and his symptoms of bipolar disorder and mania were ignored.

In the stereotype of the "evil black woman," evil describes someone who is mean, irritable, "ugly acting," and cranky. Although the connotation of evil in the occult sense does not apply here, someone who is evil is considered to be a bad person, someone to be avoided. The term *evil* often is used to describe women, particularly those who are difficult to get along with either acutely or chronically. This label is most often applied to dark-skinned women, as if to suggest that darker, more African facial features and hair texture make one more prone to being evil. This association of evilness with more African-appearing individuals may be a manifestation of internalized racism wherein dark-skinned, African traits are regarded as bad and undesirable, whereas lighter skin complexion and more European facial features are regarded as good and desirable.

Culture-Bound Syndromes

Within African American subpopulation groups, there are some culturally influenced manifestations of mood, psychotic, and dissociative disorders. Five relevant syndromes were included in DSM-IV-TR in the Glossary of Culture-Bound Syndromes (American Psychiatric Association 2000).

- *Falling-out* is defined as lapsing into a state of semiconsciousness and is thought to represent an extreme method of denial and escape from an unbearable environment.
- *Brain fag*, found primarily in Nigeria and other African cultures, is a cluster of symptoms including poor concentration or memory and thinking that results in “fatigue” in the brain and difficulty with reading, comprehending, and overall intellectual functioning. Some people with brain fag report feeling as if worms were crawling in their heads. Most symptoms center on the head and neck region and may include pressure, tension, pain, blurred vision, and a burning sensation.
- A *spell*, a culturally specific syndrome seen in African American populations, particularly in the South, involves a state of trance and communication with deceased relatives or spirits.
- *Bouffée delirante* is a syndrome found in West Africa and Haiti that is composed of a sudden onset of agitation and aggression, severe disorganized behavior, and psychomotor changes that may be accompanied by paranoid ideas or hallucinations in the auditory and visual spheres. These attacks are similar to brief psychosis.
- *Rootwork* is a culture-bound syndrome involving symptoms of mental illness believed to be caused by a hex.

CFI supplementary module 1, “Explanatory Model,” has 14 questions that are helpful in determining explanatory models (American Psychiatric Association 2013). Questions 6 and 7 are the core of the assessment: “6. Can you tell me what you think caused your [PROBLEM]?” “7. Have your ideas about the cause of the [PROBLEM] changed? How? What changed your ideas about the cause?” Question 8 focuses on how the individual is affected by his or her community: “8. What do people in your family, friends, or others in your community think caused the [PROBLEM]?”

Psychosocial Stressors and Cultural Features of Vulnerability and Resilience

In the third part of the DSM-5 OCF (American Psychiatric Association 2013), the clinician assesses how the individual relates to his or her environment and delineates stressors and supports. CFI supplementary module 3, “Social Network,” and supplementary module 4, “Psychosocial Stressors,” can help the clinician with the assessment of stressors and support. Of the 15 questions in the third module, questions 1 and 2 are helpful in assessing the structure of the network: “1. Who are the most important people in your life at present?” “2. Is there anyone in particular whom you trust and can talk with about your [PROBLEM]? Who? Anyone else?” Questions 9–11 assess how the network has been helpful or not: “9. What have your family, friends, and other people in your life done to make your [PROBLEM] better or easier for you to deal with?” “10. What kinds of help or support were you expecting from family or friends?” “11. What have your family, friends, and other people in your life done to make your [PROBLEM] worse or harder for you to deal with?” Finally, question 1 of 7 in supplementary module 4 is very helpful in assessing the role of stressors in the patient’s problem: “1. Are there things going on that have made your [PROBLEM] worse, for example, difficulties with family, work, money, or something else? Tell me more about that.”

Psychosocial stressors experienced by many African Americans are related to socioeconomic status, residence in high-crime areas, perceived racial discrimination, and perceived limitations on attainments (Baker and Bell 1999).

Among African Americans, both the nuclear family and the extended family are important. The extended family often includes nonbiological members such as friends, clergy, and godparents. It is important for the therapist to formulate a genogram that emphasizes the extended family rather than a simple biological family tree. Role flexibility is important in the African American family, and the father may not be the head—that role may be assumed by the mother, grandmother, grandfather, or other relative.

A related phenomenon is that of the *African American superwoman*, which can be particularly problematic for those with depression. This refers to women feeling that they have to do everything for everyone, not only for members of their nuclear family but also for an extended family network of relatives, friends, neighbors, and coworkers. They typically feel guilty if they

say no when asked, and they may even volunteer to help. This pattern of selflessness and martyrdom can be destructive because it may lead the individual down a path of exhaustion, denial of needs and pleasures, and self-neglect. Terri Williams (2008) in her book *Black Pain* describes how her need to help others as a social worker prevented her from recognizing her own depression despite spending days in bed.

An important source of support for African Americans is their spirituality or religion. Clinicians should not be afraid to ask about an African American patient's religious and spiritual beliefs and practices, which can be assessed with CFI supplementary module 5, "Spirituality, Religion, and Moral Traditions."

Case 1 (continued)

A large portion of Mr. Jones's symptoms appear to stem from psychosocial stressors he is experiencing. As mentioned previously, he is struggling with being caught between two worlds and not finding full support in either. This struggle may be more complicated by his perception that he has to be a strong, silent black man, much like his father. He and his wife are not seeing eye to eye on some current life values, which appears to be rooted in their different up-bringsings. He describes recent instances in which he became very irritated with coworkers in a way he would not have before. He may have some guilt feelings surrounding having "escaped" from his previous neighborhood and the fate of his peers and having gone on to college and a middle-class life. He comments that friends he grew up with do not understand his current stressors. They have said that he should "kick back," with his wife "bringing in that money." He has not been fully participating in his spiritual life, in part because of the distance to church and difference in religious background from his wife. This is likely further affecting his symptoms because it is a reduction in potential supports. In short, he feels that he is straddling two worlds. This is not uncommon for middle-class blacks from working-class backgrounds, and it relates to that sense of communal identity (see Video 3–3).

African Americans who have become successful despite adversities, such as Mr. Jones in Case 1, may experience "survivor guilt," feeling guilty that they are thriving while members of their community and their families are struggling to make ends meet. Although survivor guilt may be experienced in other cultural groups besides African Americans, given the limited societal opportunities for many blacks, the concept of survivor guilt is comparatively more common and pronounced (Naasel 2009).

African American men may express mental health needs in a way that leads to a stereotypical description of being angry, lazy, and limited in intelligence and lacking the capacity to be introspective. In particular, the “angry black male” is often misunderstood. The clinical presentation of African American men with depression may include anger, which represents a depressive equivalent. Being sad and withdrawn, more often associated with the diagnosis of depression, is the last way in which a black man in America wants to appear because of the association of sadness with weakness and vulnerability. Rather, maintaining a perpetual mask of invincibility and strength is the preferred mode of presenting and expressing oneself. Rather than appear weak, many black youths may become gangbangers and present a façade of anger and toughness. Unfortunately, angry black men are feared and are more likely to be seen as bad people who should be in the criminal justice system rather than as depressed individuals who need treatment in the mental health system.

Black patients with substance use disorders frequently have underlying mood disorders and anxiety disorders that are overlooked. Anger has been termed an idiom of distress among African Americans and, as noted earlier, can be seen as a presenting symptom of mood disorders, as opposed to the more familiar presenting symptom of sadness. In addition, a bravado style, the tendency for African American males to present themselves in a cool, confident way at all times to maintain a tough, impermeable image, can obscure underlying dysfunction and despair. Misinterpretation of this bravado or anger could contribute to the high percentage of African American males in the criminal justice system and high rates of involuntary treatment.

The story of John Henry has become the basis of a culturally mediated phenomenon of “John Henryism,” in which a black person works extremely hard to the point of exhaustion to prove his or her worth. John Henry, according to the historically based story, was born a slave in the mid-nineteenth century at a time when steam drills were used to break the rocks of mountains to make way for the construction of railroads. These steam drills obviated the need for workers to break the rock by hand with large hammers and stakes. John Henry competed with the steam drill and won, but his efforts led to his death.

Because of this phenomenon of extreme overwork and achievement seeking as a cultural response to racism and limited opportunity, clinicians should not rule out an illness such as depression in an individual who is able to func-

tion at a high level. Such culturally based compulsions defy conventional wisdom and are counterintuitive to beliefs about functional capacity in the face of serious depression. One study has characterized John Henryism as a form of active coping that carries detrimental effects of high stress. This high-effort coping response, also known as *John Henryism active coping*, has been shown to cause stress and may raise the risk of chronic disease in African Americans (Merritt et al. 2011).

Cultural Features of the Relationship Between the Individual and the Clinician

The fourth part of the DSM-5 OCF addresses the individual-clinician relationship and treatment of African Americans by both non-African American clinicians and African American clinicians (American Psychiatric Association 2013).

Aspects of recovery-oriented care, such as empowerment and person-centered care, resonate with some of the sociocultural needs of African Americans. Perceived disrespect by psychiatrists and historical misunderstandings of cultural differences have led to misdiagnosis and mistreatment. Person-centered, recovery-oriented services can help eliminate disparities for African Americans and other consumer groups who have historically received substandard care.

A black patient entering treatment may expect the therapist to have some knowledge of the effects of racism and their implication for African Americans in American society. If a black patient feels rejected or devalued by the therapist, he or she is likely to discontinue treatment. The therapist must be empathic, respectful, sensitive, and inquiring in his or her concern. Black patients' participation in treatment is influenced by the quality of the interaction between the therapist and the patient. African Americans are often more likely to see providers as monopolizing the conversation, being less willing to involve them in treatment decisions, and being less respectful. Racial bias seems to enhance these perceptions (Cooper et al. 2012). Ease of psycholinguistic communication, mutual understanding of cultural references, and avoidance of confounding the transference-countertransference issues with ethnocentrism (racial stereotyping) will facilitate the formation of a therapeutic alliance (Baker 1988; Ghods et al. 2008).

Prior to accepting services, some African Americans seek affirmation of a clinician's humanity, cultural knowledge, and relative freedom from prejudice and stereotype. Clinicians should communicate an understanding of the pervasive effects of racism and discrimination in the daily lives of their patients. Psychiatrists treating black male patients reported the following factors as most important in successful treatment: empathy, patience, supportiveness, tolerance, and the ability to listen and indicate directions without leading. These therapists also noted that racial issues must be put in perspective, that the therapist must be knowledgeable, and that he or she must gain the patient's trust. Particularly with elderly patients, clinicians need to elicit their histories carefully to form a contextual background and increase the ability to form a therapeutic alliance (Dana 2002).

When assessing a patient, it also is important to *listen* rather than immediately trying to understand the patient; to define the roles of those who accompany the patient to the sessions; to emphasize strengths rather than deficits; to be present-time focused; and to suggest a brief, focused intervention to deal with the presenting problem quickly. African Americans tend to believe that emotional problems are caused by environmental factors. They tend to prefer *concrete suggestions* regarding solutions rather than causal explanations. Recommended modalities of therapy are problem solving, social skills training, and family therapy. It is important to emphasize empowerment to help the patient gain the skills needed to make important decisions in his or her own life and the lives of family members (Paniagua 1998). It is especially important to be patient centered, focusing on respect and engagement. Such an intervention in a primary care setting reduced the rate of depression among African Americans (Cooper et al. 2010).

Given the role of religion and spirituality in the lives of many African Americans, it is important to consider these factors in evaluation and treatment. African Americans may present with psychiatric symptoms that they attribute to lack of faith or reduced participation in religious activities. Patients may also rely on their church community for support for and endorsement of their acceptance of psychiatric treatment, particularly medication. If religious factors impede progress in clinical care, it may be helpful to obtain consultation from religious leaders or cultural brokers or to make accommodations to treatment within acceptable ethical boundaries. Accommodation

may take the form of incorporating prayer into treatment, but *only* at the patient's request.

The best quality of care involves, first and foremost, treating individuals with respect and valuing them and their time. The patient's perception of the way he or she is being treated (e.g., kept waiting, spoken down to, not listened to) is key. It is important for the therapist to review evaluation findings in understandable language and to discuss the possible treatment options. With the individual's consent, it is essential to explain the treatment process to family members and to encourage their involvement in the treatment process. Both patients and their family members or caregivers should be included in educational programs (i.e., family psychoeducation) about the patient's illness and the effects of medication.

The effect of racism must always be considered in the assessment of African Americans, regardless of whether or not it appears to be a presenting problem or a contributing factor to psychopathology. African Americans may present as highly suspicious of others with different ethnicity and values. This is known as the *healthy paranoia effect* and results from adaptation to the effects of slavery and racism. If patient and therapist are not of the same race, it is important that the therapist acknowledge the difference during the first session and encourage the patient to discuss his or her feelings about the issue (Dana 2002).

Black patients can be defensive, hostile, and nonverbal in an initial meeting in a new setting, in part as an adaptation to powerlessness. They may experience fear and distrust of white therapists. If black patients believe the goal of therapy is to maintain the status quo and their place in society, they may be suspicious of the motives of black as well as white psychiatrists.

Communication and language are important aspects of identity. African American patients prefer personalized interactions that include a greeting, an introduction of the provider to the patient, and a handshake. They may prefer to be greeted by their surnames, and in the South they may prefer to be greeted as "sir" or "ma'am" (Kaiser Permanente 2003).

African Americans may use street talk, black English, or Ebonics, which are variations of nonstandard English that may be difficult to comprehend. If the therapist cannot understand the patient, it is important to ask directly about whatever specifically is not understood. It is important that the patient understand that the therapist is not questioning the correctness of his or her

use of language but rather is trying to facilitate communication between the two so that the patient's main concerns can be understood (Paniagua 1998).

Nonverbal communication refers to gestures, posture, eye contact, and interpersonal distance. It is not uncommon for African Americans to use subverbal utterances, such as “umnh, umnh, umnh” or grunts, and other nonverbal sounds to indicate, without talking, that they are listening or to convey an emotional response to something that has been said. African Americans tend to prefer a narrower space between conversants, in contrast to a preferred wider distance among whites (Primm et al. 1996). The potential risk in cross-cultural situations is a mismatch in preferred distance, giving the African American patient a sense of being rejected by the therapist and the therapist a sense of being crowded. Such a situation could result in difficulties in establishing a therapeutic alliance, in misdiagnosis, or in early termination by the patient.

Eye contact is another manifestation of nonverbal communication to which mental health professionals pay close attention. African Americans, like other nonwhite racial groups, consider sustained, direct eye contact rude and disrespectful to authority. Touching between patient and therapist is usually considered taboo in the mental health encounter. However, among African Americans, a touch or an embrace is an acceptable and desirable way to convey warmth, acceptance, and consolation (Primm et al. 1996).

The negative ways in which society views black people provide a lens for comprehending the great hurdles they must surmount in order to enter and engage with the clinical setting and the clinician. Cultural beliefs add to this dynamic with explanations of psychopathology and culturally determined states of being, which contribute to shunning psychiatric care and for some the embrace of alternative sources such as family, folk healing, and faith-based services. Even entering the door of the psychiatric setting at all often means overcoming multiple barriers to mental health care. In the relationship between the individual and the clinician, respect and a recovery-oriented approach and fostering of empowerment and hopefulness are key to making the clinical environment a safe space for healing. Consciousness of racial and ethnic differences in psychiatric epidemiology, diagnostic realities, and treatment disparities that exist should help the clinician to incorporate all of these factors and apply them consciously and deliberately in their work with individuals of African descent so as not to inadvertently drive them away from care as a result of even unconscious actions that might underlie poor quality of care and poor

outcomes in well-being, functioning, satisfaction with care, and the achievement of an effective partnership within the therapeutic dyad.

CFI supplementary module 8, “Patient-Clinician Relationship,” can be helpful in assessing the effect of ethnic identity on the therapeutic relationship, with its five questions for the patient and seven questions for the clinician. Question 4 is particularly useful in opening up a dialogue between the patient and the clinician (American Psychiatric Association 2013): “Sometimes differences among patients and clinicians make it difficult for them to understand each other. Do you have any concerns about this? If so, in what way?”

Substantial quantitative and qualitative evidence casts doubt on the notion that racially/ethnically matching clinicians and patients actually improves mental health care (Good et al. 2011). Aside from the issue of language matching, Good and colleagues suggest that clinicians should pay more attention to the larger context that shapes patients’ experiences: social class, education level, level of familiarity with biomedical or hospital settings, level of comfort with institutional bureaucracy, and level of scientific literacy.

Case 1 (continued)

At the beginning of his session, Mr. Jones indicated that he was reluctant to be completely open about what was going on (“I barely know you.... I just met you today” [not shown]). This may speak to a concern on the part of the patient that there is not yet the sense of connection necessary to allow full disclosure. Mr. Jones goes on to say later in the interview that he has been reluctant to discuss issues with individuals outside his family. This is very common with African American patients and a potential barrier that the clinician must overcome. In this situation, the clinician did a very nice job of showing empathy, patience, tolerance, and supportiveness. This likely helped the patient feel comfortable in disclosing more information.

Table 3–2 identifies skills, positive aspects and omissions, and areas of improvement for the clinician in the videos for Case 1. The therapist incorporated two questions (questions 1 and 4) from the CFI in Video 1–1. See Video 3–6 for a discussion of how to approach a patient who feels that the clinician might not understand his or her issues because he or she does not belong to the same culture. Dr. Boehnlein stresses that clinicians may have difficulty

with patients from similar backgrounds because of incorrect assumptions and suggests treating each patient as a microculture.



Video Illustration 3–6: Mixed therapist-patient dyad (3:52)

Overall Cultural Assessment

The fifth part of the DSM-5 OCF (American Psychiatric Association 2013) addresses the question of how cultural factors affect diagnosis and treatment of African American patients. The information contained in this chapter provides a foundation for understanding cultural issues informing overall diagnosis and care. Appreciating the national and regional origins of the individual and the within-group diversity among people of African descent is essential. Understanding the history of this group of people, including historical traumas, provides a context for appreciating the lack of trust and concerns that arise when people are contemplating seeking professional help for their mental health needs.

African Americans' attitudes toward mental illness are a major barrier to accessing care. The stigma of mental illness is high among African Americans, and seeking treatment is not always encouraged. African Americans are also less likely than whites to have positive attitudes about friends having knowledge of their mental health help seeking (Diala et al. 2002). As mentioned, mistrust, dislike, or fear of the mental health system and providers is also common. Clinicians should be prepared to explore antipsychiatry feelings with their African American patients in an effort to counteract the negative effects of antipsychiatry perceptions they may have.

Case 1 (continued)

Dr. Boehnlein did a good job of listening to what Mr. Jones was saying rather than immediately jumping to conclusions or assumptions. At the end of the session, he also provided concrete suggestions about how to approach the issues that Mr. Jones is having, including the possibility of bringing in his wife for family therapy. This is important because it shows that the clinician understands the importance of the family unit and outside supports in treatment. Dr. Boehnlein also suggested the use of medication, which was a sensitive area for Mr. Jones, who believed that was a treatment option he

Table 3–2. Critique of therapist and skills

Skills and positive aspects	Omissions and areas needing improvement
The interview was solid and sound overall, and the therapist elicited a considerable amount of valuable information.	The therapist needed to ask more open-ended questions. Too many questions elicited brief “yes/no” answers.
The therapist had the beginnings of a good rapport, setting the stage appropriately for the therapeutic relationship, and seemed welcoming (e.g., asking about parking and helping the patient feel comfortable [not shown]).	The therapist never explicitly opened the door to discuss culture (e.g., during the religion discussion, he did not give the patient an opportunity to reflect on the cultural differences between Baptist and Catholic church services, the former being more “spirited.” This is actually a stereotype, and the therapist should have let the patient describe his impression of the contrast (see Video 3–2).
The therapist used a joining statement, setting up a partnership with the patient (see Video 3–4).	The therapist asked the patient how he coped with and adjusted to being different from his friends from his neighborhood who did not pursue higher education as well as being different from college classmates. The therapist jumped to the patient’s handling of the situation instead of first exploring how being so different from the group in two social situations, essentially in a no-man’s land, made the patient feel (see Video 3–1).
The therapist probed appropriately with the presenting problem, initially clarifying questions to focus on what the patient thought about his problems and not just what his wife thought that drove him into therapy.	The therapist often asked compound questions, posing too many questions at once.

Table 3–2. Critique of therapist and skills (*continued*)

Skills and positive aspects	Omissions and areas needing improvement
The therapist used brief phrases to indicate that he was following the patient's narrative.	The therapist missed the opportunity to have the patient elaborate freely about his marriage by not asking open-ended questions, such as "Tell me about your marriage." The therapist seemed to drive the parameters of the patient's thinking, thereby blocking important information.
The therapist used skills of probing and asking open-ended questions about how it felt for the patient to be different from his peers in terms of going off to college while leaving his friends back home (see Video 3–1).	The therapist did not explore the meaning of the patient's body language or nonverbal signs of displeasure when he mentioned feeling like "Mr. Mom" and a househusband. He may have been feeling anger or resentment, particularly given the black male cultural perspective. The therapist could have used the technique of bridging between these terms (Mr. Mom, househusband) and their meaning to the patient because they were brought up in different parts of the interview (see Video 3–4).
The therapist showed good summarizing skill at the end of the session (see Video 3–4).	The therapist jumped to an interpretation regarding the pressure associated with the patient's wife and her family but never let the patient expound on this. His interpretation may have been correct but was premature (see Video 3–4).
	Near the end of the session, the therapist began a discussion of medication that may have brought up strong feelings in the patient given that many African Americans are reluctant to use medication because of concerns about stigma or addiction. The therapist could have explored the resistance with the patient or involved him more by commenting on his strong reaction (see Video 3–4).

Table 3–2. Critique of therapist and skills (*continued*)

Skills and positive aspects	Omissions and areas needing improvement
	Labeling the patient as depressed may have been premature. There would have been ample opportunity in the follow-up visit to explore more comprehensively (see Video 3–4).

would not accept because of the stigma associated with taking medications in his community. The issue of medications could have been explored more, and some negotiation might have been useful, because the discussion was one-sided.

One area that could have been explored more by the clinician was the role of race in the patient’s life. Although the clinician spent a great deal of time exploring themes and paths that are culturally rich, he did not explicitly ask about the role of race and culture in this patient’s life. If Dr. Boehnlein had overtly asked about these issues, he would have opened the door for Mr. Jones to feel comfortable talking about race and culture as they relate to his life. This not only would have given very valuable clinical information but also would have shown the patient that the clinician was comfortable exploring these areas. It is important to show that these are appropriate topics within the therapeutic setting because of the fact that the patient and clinician are of differing backgrounds, which Mr. Jones commented on (“Doc, you ever been to East Oakland?”) (see Video 3–1).

Some research has found that African Americans in the general community and those with diagnoses of depression had more positive views about seeking mental health care than did their white counterparts. This seems somewhat paradoxical given that African Americans were less likely to use mental health services. Furthermore, compared with whites, African Americans who had used mental health services were more likely to have negative attitudes and were less likely to continue with treatment (Diala et al. 2002).

One element of the cultural formulation, *cultural concepts of distress*, can come into play when the patient and clinician are from different cultural groups. The difference in backgrounds can contribute to misinterpretation of the patient’s complaints and misunderstanding of the patient’s history.

Case 4

Mr. T. is a 52-year-old African man from the Ivory Coast. He came to the United States as a refugee 8 months prior to presenting for therapy. He was referred by his case manager because of concerns that he was having a difficult time adjusting to “the system.” Mr. T. came to the United States because of political persecution in his home country, and his wife and their three children came along with him. Once in the United States, his wife charged him with domestic violence. He was having tremendous difficulty dealing with the legal system. He believed that the court system was trying to tear his family apart. He vehemently denied that he committed the crime he was accused of committing.

While in the United States, Mr. T. began working as cabdriver. As a result of tickets and fines, Mr. T. had his license revoked and was unable to work, which has caused him great financial difficulty. During the sessions, he talked a great deal about how the United States is focused on money and how he would prefer to return to his home country. However, he was not able to do that at the time, and this caused him great distress.

During sessions, he became quite upset. His speech was seemingly pressured, with increased volume, and he would become tearful. It was difficult to interject, especially because an interpreter had to be used for all of the sessions (although Mr. T. had some ability to speak and understand English). He was upset at the American system in general and frustrated that his issues were not being resolved. He made threats about killing himself if he were sentenced to prison but was vague when asked about current suicidal ideations.

There were two main challenges in treating Mr. T. The first one was clarifying the diagnosis so that an appropriate treatment strategy could be developed. The standard Western description of psychiatric illness would likely lead to a diagnosis of bipolar disorder, given the elevation of mood presentation. However, the treatment providers believed that this was not a manic presentation but rather a culturally appropriate expression of distress consistent with a dysphoric mood or adjustment disorder.

The second issue was working with Mr. T. in a way that was helpful to him and within his understanding of the purpose of the sessions. It appeared that he viewed the therapist and psychiatrist as an extension of his case management team and would spend large portions of the appointments talking about his legal issues and how to resolve them. When attempts were made to redirect him to “therapeutic” topics, he became increasingly upset and said that his needs were not being met. Mr. T.’s perspective presents a challenge to the clinician in making clear the “purpose” of mental health treatment while also addressing his needs.

In addition, Mr. T. viewed the psychiatrist as a primary care doctor and spent a great deal of time talking about his somatic needs. The psychiatrist needed to determine whether the somatic complaints were the patient's way of expressing emotional distress or whether he truly needed additional medical care.

Clinicians walk a fine line between using clinical training to assess and treat the patient while at the same time not becoming so "stuck" in a line of questioning that the actual needs of the patient are missed. The challenge was even more pronounced in the case of Mr. T. given the treatment provider's limited understanding of the patient's language, culture, and how he described and experienced his mental health. Being conscious of the background and perspectives of the individual and learning more about his or her culture can help the clinician provide quality care.

It has been well documented that African Americans are disproportionately diagnosed with schizophrenia compared with whites. This trend is in conflict with the results of epidemiological studies that show similar prevalence of psychotic disorders among African Americans, Latinos, and non-Latino whites (Barnes 2008; Gara et al. 2012). African Americans frequently receive misdiagnoses of schizophrenia when they actually have a mood disorder such as bipolar disorder. At first presentation in any group, bipolar disorder is often misdiagnosed, but this is even more pronounced among African Americans. Schizophrenia is often mistakenly diagnosed when the presenting symptoms are irritability, anxiety, delusions, and hallucinations. Many factors contribute to misdiagnosis, including insufficient use of differential diagnosis techniques, not taking into account that schizophrenia is a diagnosis of exclusion after mood disorder is ruled out, cultural factors, and stereotypical beliefs held by practitioners. Use of screening tools and diagnostic instruments theoretically should help to improve diagnostic accuracy in the evaluation of African American patients (Primm and Lawson 2010).

In a recent study (Gara et al. 2012), researchers identified that clinicians overemphasize psychotic symptoms compared with affective symptoms in African American patients. The presence of hallucinations and delusions in African American patients tends to prompt a limited review of diagnoses in the differential diagnosis process, even though schizophrenia is regarded as a diagnosis of exclusion. Although African American and white participants were similar in blind raters' assessments of mood symptoms, the African American

patients received higher assessments of psychotic disorder. This suggests that greater value was placed on psychotic symptoms in African American subjects, thus resulting in greater skewing toward diagnoses in the schizophrenia spectrum. This study found that the higher rates of schizophrenia diagnoses among African Americans compared with white subjects persisted after controlling for various confounding factors. The authors concluded that their results remind clinicians to “consistently challenge their own diagnostic assessments particularly in patients from other ethnic groups.... [C]areful reconsideration of the criteria underlying diagnoses in all patients... may help minimize racial disparities in psychiatric practices” (Gara et al. 2012, p. 599).

In his book *The Protest Psychosis: How Schizophrenia Became a Black Disease*, psychiatrist and author Jonathan Metzl, M.D., looks at how the association between schizophrenia and African Americans emerged amid the Civil Rights protests of the 1960s and 1970s. He argues that the “civil rights—era anxieties about racial protest catalyzed associations between schizophrenia, criminality, and violence.... [T]he newly narrowed frame surrounding schizophrenia circumscribed and helped create the category of angry, black, male schizophrenic subjects....” (Metzl 2009, p. xix).

Conclusion

With the review of the cultural formulation in the context of the clinician-individual dyad in the video case and the additional examples presented, the goal is for the reader to appreciate the various dimensions in which culture enters the equation for the clinical encounter and use this understanding to better provide culturally informed, effective, and responsive care.

The perspectives presented here are merely a selection of key issues to consider when treating African Americans with mental health needs; readers are encouraged to seek more information on an ongoing basis as more studies emerge with data and analyses of the intersection of ethnic and racial difference, culture, mental illness, and mental health care and to add these insights to their armamentarium in order to provide the highest quality care possible for African American patients.

As described in this chapter, African Americans may experience numerous factors that make them more susceptible to developing mental illness, but

they are less likely to receive mental health treatment. This occurs for many reasons, including mistrust of the mental health community, less access to care, cost of treatment, delays in seeking treatment spurred on by community stigma, and individuals seeking help from non-mental health sources. Even when African Americans do receive treatment, it is of poorer quality than that received by their white counterparts. This may be a result of cultural differences in symptom presentation and overvaluation of psychotic symptoms that can lead to misdiagnosis in African American patients. Also, decreased efficacy in treatment can be attributed to decisions made about medications and other treatment modalities prescribed to African American patients. If mental health practitioners are going to help overcome these health care disparities, they must recognize the barriers to treatment and use skills that will foster a therapeutic relationship and help African Americans benefit from treatment.

The DSM-5 OCF and CFI provide the clinician with the framework and tools (questions) to explore the patient's cultural identity, health beliefs, stressors, and supports and the relationship between the clinician and the patient, as well as aid the clinician in developing a culturally appropriate diagnosis and treatment plan.

In working with African Americans, clinicians should remember to use a person-centered approach with a cooperative communication style. Empathy, respect, sensitivity, and an inquiring nature should be used. Concrete solutions should be offered whenever possible with an emphasis on patients' strengths and ways to use those strengths to solve problems. The role that race plays in the person's life and in his or her understanding of the world must always be considered. In addition, the role of the extended family, as well as community and spirituality, must be examined for how they provide support to the patient. The clinician must have an understanding of culturally relevant themes and a willingness to explore these themes. By keeping these things in mind, the mental health clinician will go a long way in providing quality care to African Americans.

References

- Agency for Healthcare Research and Quality: 2010 National Healthcare Quality and Disparities Reports. Rockville, MD, Agency for Healthcare Research and Quality, 2011. Available at: <http://www.ahrq.gov/research/findings/nhqdr/nhqdr10/qdr10.html>. Accessed May 6, 2014.
- Ahern J, Galea S: Collective efficacy and major depression in urban neighborhoods. *Am J Epidemiol* 173(12):1453–1462, 2011
- Akincigil A, Olfson M, Siegel M, et al: Racial and ethnic disparities in depression care in community-dwelling elderly in the United States. *Am J Public Health* 102(2):319–328, 2012
- Alexander M: *The New Jim Crow*. New York, New Press, 2010
- American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition. Washington, DC, American Psychiatric Association, 1994
- American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000
- American Psychiatric Association: *Mental Health: A Guide for African Americans and Their Families*. Washington, DC, American Psychiatric Association, 2011
- American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition. Washington, DC, American Psychiatric Association, 2013
- Anglin DM, Alberti PM, Link BG, et al: Racial differences in beliefs about the effectiveness and necessity of mental health treatment. *Am J Community Psychol* 42(1–2):17–24, 2008
- Bailey RK, Blackmon HL, Stevens FL: Major depressive disorder in the African American population: meeting the challenges of stigma, misdiagnosis, and treatment disparities. *J Natl Med Assoc* 101(11):1084–1089, 2009
- Baker FM: Afro American, in *Clinical Guidelines in Cross-Cultural Mental Health*. Edited by Comas-Díaz L, Griffith EHE. New York, Wiley, 1988, pp 151–181
- Baker FM, Bell CC: Issues in the psychiatric treatment of African Americans. *Psychiatr Serv* 50(3):362–368, 1999
- Barnes A: Race and hospital diagnoses of schizophrenia and mood disorders. *Soc Work* 53(1):77–83, 2008
- Berry B: Colorism, in *Encyclopedia of Gender and Society*, Vol 1. Thousand Oaks, CA, Sage, 2009. Available at: <http://knowledge.sagepub.com/view/gender/n82.xml>. Accessed May 6, 2014.
- Bradford LD: The ethnopharmacology of atypical antipsychotics. *CNS Spectr* 10(3) (suppl 2):6–12, 2005

- Breslau J, Kendler KS, Su M, et al: Lifetime risk and persistence of psychiatric disorders across ethnic groups in the United States. *Psychol Med* 35(3):317–327, 2005
- Bresnahan M, Begg MD, Brown A, et al: Race and risk of schizophrenia in a US birth cohort: another example of health disparity? *Int J Epidemiol* 36(4):751–758, 2007.
- Centers for Disease Control and Prevention: Summary Health Statistics for the U.S. Population, National Health Interview Survey, 2010. Atlanta, GA, Centers for Disease Control and Prevention, 2011. Available at: <http://www.cdc.gov/nchs/products/series/series10.htm>. Accessed May 6, 2014.
- Chou T, Asnaani A, Hofmann SG: Perception of racial discrimination and psychopathology across three U.S. ethnic minority groups. *Cultur Divers Ethnic Minor Psychol* 18(1):74–81, 2012
- CNN: Study: white and black children biased toward lighter skin. May 14, 2010. Available at: <http://www.cnn.com/2010/US/05/13/doll.study/index.html>. Accessed May 6, 2014.
- Cooper LA, Ford DE, Ghods BK, et al: A cluster randomized trial of standard quality improvement versus patient-centered interventions to enhance depression care for African Americans in the primary care setting: study protocol NC T00243425. *Implement Sci* 5:18, 2010
- Cooper LA, Roter DL, Carson KA, et al: The associations of clinicians' implicit attitudes about race with medical visit communication and patient ratings of interpersonal care. *Am J Public Health* 102(5):979–987, 2012
- Dana RH: Mental health services for African Americans: a cultural/racial perspective. *Cultur Divers Ethnic Minor Psychol* 8(1):3–18, 2002
- Diala C, Muntaner C, Walrath C, et al: Racial differences in attitudes toward professional mental health care and the use of services, in *Race, Ethnicity, and Health*. Edited by LaVeist TA. San Francisco, CA, Jossey-Bass, 2002, pp 578–591
- Duke B, Berry DC: *Dark Girls*. Los Angeles, CA, Duke Media and Urban Winter Entertainment, 2011
- Frey WH: *Melting Pot Cities and Suburbs: Racial and Ethnic Change in Metro America in the 2000s*. Washington, DC, The Brookings Institution, 2011. Available at: http://www.brookings.edu/-/media/Files/rc/papers/2011/0504_census_ethnicity_frey/0504_census_ethnicity_frey.pdf. Accessed May 6, 2014.
- Gara MA, Vega WA, Arndt S, et al: Influence of patient race and ethnicity on clinical assessment in patients with affective disorders. *Arch Gen Psychiatry* 69(6):593–600, 2012

- Ghods BK, Roter DL, Ford DE, et al: Patient-physician communication in the primary care visits of African Americans and whites with depression. *J Gen Intern Med* 23(5):600–606, 2008
- Good MD, Willen SS, Hannah SD, et al: *Shattering Culture: American Medicine Responds to Cultural Diversity*. New York, Russell Sage Foundation, 2011
- Government Accountability Office: *African American Children in Foster Care: Additional HHS Assistance Needed to Help States Reduce the Proportion in Care* (GAO 07-816). Washington, DC, General Accounting Office, 2007. Available at: <http://www.gao.gov/new.items/d07816.pdf>. Accessed May 6, 2014.
- Griffith DM, Johnson JL, Zhang R, et al: Ethnicity, nativity, and the health of American Blacks. *J Health Care Poor Underserved* 22(1):142–156, 2011
- Insight Center for Community Economic Development: *Lifting as We Climb: Women of Color, Wealth, and America's Future*. Oakland, CA, Insight Center for Community Economic Development, 2012. Available at: <http://www.insightcced.org/uploads/CRWG/LiftingAsWeClimb-WomenWealth-Report-InsightCenter-Spring2010.pdf>. Accessed May 6, 2014
- Jackson JS, Knight KM, Rafferty JA: Race and unhealthy behaviors: chronic stress, the HPA axis, and physical and mental health disparities over the life course. *Am J Public Health* 100(5):933–939, 2010
- Johnson RL, Roter D, Powe NR, et al: Patient race/ethnicity and quality of patient-physician communication during medical visits. *Am J Public Health* 94(1):2084–2090, 2004
- Jones CP, Truman BI, Elam-Evans LD, et al: Using “socially assigned race” to probe white advantages in health status. *Ethn Dis* 18(4):496–504, 2008
- Kaiser Permanente: *A Provider's Handbook on Culturally Competent Care: African American Population*, 2nd Edition. Oakland, CA, Kaiser Permanente, 2003. Available at: <http://kphci.org/downloads/KP.PHandbook.AfricanAmerican.2nd.2003.pdf>. Accessed May 6, 2014.
- Kessler RC, Berglund P, Demler O, et al: Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry* 62(6):593–602, 2005
- Krugman P: How fares the dream? *The New York Times*, January 15, 2012. Available at: <http://www.nytimes.com/2012/01/16/opinion/krugman-how-fares-the-dream.html>. Accessed May 6, 2014.
- Lawson WB: Mental health issues for African Americans, in *Handbook of Racial and Ethnic Minority Psychology*. Edited by Guillermo B, Trimble JE, Burlew AK. Thousand Oaks, CA, Sage, 2002, pp 561–569

- Lawson WB: Identifying interethnic variations in psychotropic response in African Americans and other ethnic minorities, in *Ethno-Psychopharmacology Advances in Current Practice*. Edited by Ng CH, Lin KM, Singh BS. Melbourne, Australia, Cambridge University Press, 2007, pp 111–117
- Lo CC, Cheng TC: Racial/ethnic differences in access to substance abuse treatment. *J Health Care Poor Underserved* 22(2):621–637, 2011
- Logan JR: *Separate and Unequal: The Neighborhood Gap for Blacks, Hispanics and Asians in Metropolitan America*. Providence, RI, Brown University, 2011. Available at: <http://www.s4.brown.edu/us2010/Data/Report/report0727.pdf>. Accessed May 6, 2014.
- Marques L, Alegria M, Becker AE, et al: Comparative prevalence, correlates of impairment, and service utilization for eating disorders across US ethnic groups: implications for reducing ethnic disparities in health care access for eating disorders. *Int J Eat Disord* 44(5):412–420, 2011
- Mercer SH, Zeigler-Hill V, Wallace M, et al: Development and initial validation of the Inventory of Microaggressions Against Black Individuals. *J Couns Psychol* 58(4):457–469, 2011
- Merritt MM, McCallum TJ, Fritsch T: How much striving is too much? John Henryism active coping predicts worse daily cortisol responses for African American but not white female dementia family caregivers. *Am J Geriatr Psychiatry* 19(5):451–460, 2011
- Metzl J: *The Protest Psychosis: How Schizophrenia Became a Black Disease*. Boston, MA, Beacon Press, 2009
- Miranda J, McGuire T, Williams D, et al: *Reducing Mental Health Disparities: General vs. Behavioral Health Policy*. MacArthur Foundation Issue Brief. Chicago, IL, MacArthur Foundation Network on Mental Health Policy Research, 2008. Available at: <http://www.macfound.org/media/files/DISPARITIES.PDF>. Accessed May 6, 2014.
- Naasel KR: Survivor's guilt? *Black Enterprise*, Oct 1, 2009. Available at: <http://www.Blackenterprise.com/2009/10/01/survivor%E2%80%99s-guilt/>. Accessed May 6, 2014.
- National Center for Health Statistics: *Health, United States, 2012 With Special Feature on Emergency Care*. Hyattsville, MD, National Center for Health Statistics, 2013. Available at: [http://www.cdc.gov/nchs/data/12.pdf](http://www.cdc.gov/nchs/data/hus/12.pdf). Accessed May 15, 2014.
- National Park Service: *Jim Crow Laws*. Martin Luther King Jr. National Historic Site, 2014. Available at: http://www.nps.gov/malu/forteachers/jim_crow_laws.htm. Accessed May 15, 2014.

- Neighbors HW, Caldwell C, Williams DR, et al: Race, ethnicity, and the use of services for mental disorders: results from the National Survey of American Life. *Arch Gen Psychiatry* 64(4):485–494, 2007
- Newport F: Religion most important to blacks, women, and older Americans. Gallup News Service, November 29, 2006. Available at: <http://www.gallup.com/poll/25585/religion-most-important-Blacks-women-older-americans.aspx>. Accessed May 6, 2014.
- Office of Minority Health: African American Profile. Rockville, MD, U.S. Department of Health and Human Services, 2005. Available at: <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=51>. Accessed May 6, 2014.
- Paniagua F: Guidelines for the assessment and treatment of African American clients, in *Assessing and Treating Culturally Diverse Clients*. Thousand Oaks, CA, Sage, 1998, pp 20–37
- Pierce CM: Offensive mechanism: the vehicle for microaggression, in *The Black 70s*. Edited by Barabour FB. Boston, MA, Porter Sargent, 1970, pp 265–282
- Pratt LA, Brody DJ: Depression in the United States Household Population, 2005–2006. Hyattsville, MD, National Center for Health Statistics, 2008. Available at: <http://www.cdc.gov/nchs/data/databriefs/db07.htm>. Accessed May 6, 2014.
- Primm A, Lawson WB: African Americans, in *Disparities in Psychiatric Care: Clinical and Cross-Cultural Perspectives*. Edited by Ruiz P, Primm A. Washington, DC, Lippincott, Williams & Wilkins, 2010, pp 19–29
- Primm AB, Lima BR, Rowe CR: Cultural and ethnic sensitivity, in *Integrated Mental Health Services: Modern Community Psychiatry*. Edited by Breakey W. New York, Oxford University Press, 1996, pp 146–159
- Primm AB, Cabot D, Pettis J, et al: The acceptability of a culturally tailored depression education videotape to African Americans. *J Natl Med Assoc* 94(11):1007–1016, 2002
- Roberts AL, Gilman SE, Breslau J, et al: Race/ethnic differences in exposure to traumatic events, development of post-traumatic stress disorder, and treatment-seeking for post-traumatic stress disorder in the United States. *Psychol Med* 41(1):71–83, 2011
- Soto JA, Dawson-Andoh NA, BeLue R: The relationship between perceived discrimination and generalized anxiety disorder among African Americans, Afro Caribbeans, and non-Hispanic Whites. *J Anxiety Disord* 25(2):258–265, 2011
- Sribney W, Elliott K, Aguilar-Gaxiola S, et al: The role of nonmedical human services and alternative medicine, in *Disparities in Psychiatric Care: Clinical and Cross-Cultural Perspectives*. Edited by Ruiz P, Primm A. Baltimore, MD, Lippincott Williams & Wilkins, 2010, pp 274–289

- Strickland TL, Stein R, Lin KM, et al: The pharmacologic treatment of anxiety and depression in African Americans: considerations for the general practitioner. *Arch Fam Med* 6(4):371–375, 1997
- Substance Abuse and Mental Health Services Administration: The NSDUH Report: Substance Use Among Black Adults. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2010. Available at: <http://www.samhsa.gov/data/2k10/174/174SubUseBlackAdults.htm>. Accessed May 6, 2014.
- Thompson RF: *Flash of the Spirit: African and Afro-American Art and Philosophy*. New York, Vintage Books, 1984
- Trinidad DR, Pérez-Stable EJ, White MM, et al: A nationwide analysis of US racial/ethnic disparities in smoking behaviors, smoking cessation, and cessation-related factors. *Am J Public Health* 101(4):699–706, 2011
- Underhill, W: Voter Identification Requirements. National Conference of State Legislatures, 2014. Available at: <http://www.ncsl.org/research/elections-and-campaigns/voter-id.aspx>. Accessed May 15, 2014.
- U.S. Census Bureau: Race and Hispanic Origin of the Foreign-Born Population in the United States: 2007. American Community Survey Reports. Washington, DC, U.S. Census Bureau, 2010. Available at: <http://www.census.gov/prod/2010pubs/acs-11.pdf>. Accessed May 6, 2014.
- U.S. Census Bureau: America's Families and Living Arrangements: 2011. Washington, DC, U.S. Census Bureau, 2011a. Available at: <http://www.census.gov/population/www/socdemo/hh-fam/cps2011.html>. Accessed May 6, 2014.
- U.S. Census Bureau: Current Population Survey, 2011 Annual Social and Economic Supplement. Washington, DC, U.S. Census Bureau, 2011b. Available at: <http://www.census.gov/prod/techdoc/cps/cpsmar11.pdf>. Accessed May 6, 2014.
- U.S. Census Bureau: Income, Poverty, and Health Insurance Coverage in the United States: 2010. Washington, DC, U.S. Census Bureau, 2011c. Available at: <http://www.census.gov/prod/2011pubs/p60-239.pdf>. Accessed May 6, 2014.
- U.S. Department of Health and Human Services: Mental Health: Culture, Race and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD, U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General, 2001. Available at: <http://www.surgeongeneral.gov/library/mentalhealth/cre>. Accessed May 6, 2014.
- U.S. Department of Justice: Bureau of Justice Statistics. 2010. Prison Inmates for 2010—Statistical Tables and Prisoners at Year-End 2010. Advance Counts. Washington, DC, U.S. Department of Justice, 2010. Available at: <http://bjs.ojp.usdoj.gov/content/pub/press/pim09stpy09acpr.cfm>. Accessed May 6, 2014.

- U.S. Department of Justice: Prison and Jail Inmates at Midyear 2003–2007. Washington, DC, U.S. Department of Justice, Office of Justice Programs, 2007. Available at: <http://bjs.gov/index.cfm?ty=pbse&zsid=38>. Accessed May 6, 2014.
- Virnig B, Huang Z, Lurie N, et al: Does Medicare managed care provide equal treatment for mental illness across races? *Arch Gen Psychiatry* 61(2):201–205, 2004
- Wilkerson I: *The Warmth of Other Suns: The Epic Story of America's Great Migration*. New York, Random House, 2010
- Williams DR, González HM, Neighbors H, et al: Prevalence and distribution of major depressive disorder in African Americans, Caribbean blacks, and non-Hispanic whites: results from the National Survey of American Life. *Arch Gen Psychiatry* 64(3):305–315, 2007
- Williams T: *Black Pain: It Just Looks Like We're Not Hurting*. New York, Scribner, 2008
- Woodward AT, Taylor RJ, Chatters LM: Use of professional and informal support by black men with mental disorders. *Res Soc Work Pract* 21(3):328–336, 2011
- Woodward AT, Taylor RJ, Bullard KM, et al: Prevalence of lifetime DSM-IV affective disorders among older African Americans, Black Caribbeans, Latinos, Asians and non-Hispanic White people. *Int J Geriatr Psychiatry* 27(8):816–827, 2012
- Young AS, Klap R, Sherbourne CD, et al: The quality of care for depressive and anxiety disorders in the United States. *Arch Gen Psychiatry* 58(1):55–61, 2001

This page intentionally left blank

Issues in the Assessment and Treatment of Asian American Patients

Nang Du, M.D.

Russell F. Lim, M.D., M.Ed.

Asian Americans are the third largest and the fastest growing minority group in the United States, with a population of 10.2–11.9 million according to the 2000 U.S. Census, increasing to 14.7 million according to the 2010 U.S. Census, an increase of 43%, matched by the Hispanic population (U.S. Census Bureau 2001, 2011). The category of Asian American includes at least 43 ethnic subgroups (Lee 1998) with many different languages and dialects, religious beliefs, immigration patterns, socioeconomic statuses, and traditional patterns of seeking health care. These cultural and social variables affect psychiatric disorders in Asian Americans' manifestation of psychiatric symptoms, help-seeking behaviors, treatment strategies, compliance, and out-

comes. In this chapter, we provide an overview of the historical backgrounds of the various groups and some culturally appropriate practical assessment techniques and therapeutic approaches organized around the DSM-5 Outline for Cultural Formulation (OCF; American Psychiatric Association 2013).

Overview of the Asian American Population

In 1970, the Asian American population was reported to be 1.5 million; in 1980, this number had exploded to 3.5 million, and by 1990, that number more than doubled to 7.2 million. From 2000 to 2010, the Asian American population increased 43% to 14.7 million. The 2010 U.S. Census reported 14.7 million Asian Americans and an additional 2.2 million who identified themselves as Asian in combination with another race. Most Asian Americans live in California, Hawaii, New York, Texas, New Jersey, Illinois, Washington, Florida, Virginia, or Massachusetts. Their populations are concentrated in metropolitan areas, such as New York City and Los Angeles, which are the U.S. cities with the largest Asian American populations (U.S. Census Bureau 2011). See Table 4–1 for more comparisons of the Asian American population.

Immigration Patterns

Because of the wide variety of experiences among Asian Americans, knowledge of Asian American background and preimmigration experience is essential in understanding possible traumatic experiences during the immigration process and journey, as well as postimmigration acculturation and assimilation stress.

Asian Americans came to the United States at different periods, by different routes, and for different reasons. Some came for economic reasons, whereas others were seeking a safe haven and freedom from persecution. Many Asian Americans who have survived flights from their home countries have suffered traumatic experiences caused by famine, war, political imprisonment, and persecution. American domestic and foreign policy, along with global political and economic events, have strongly influenced Asian Ameri-

Table 4–1. Major Asian American groups in the 2010 U.S. Census

Race	Census 2000		Census 2010		Change 2000–2010	
	Population	Percentage	Population	Percentage	Population	Percentage
Total population	281,421,906	100.0	308,745,538	100.0	27,323,632	9.71
Asian	10,242,998	3.6	14,674,252	4.8	4,431,254	43.26
Asian Indian	1,678,765	0.6	2,843,391	0.9	1,164,626	69.37
Chinese	2,432,585	0.9	3,347,229	1.1	914,644	37.60
Filipino	1,850,314	0.7	2,555,923	0.8	705,609	38.13
Japanese	796,700	0.3	763,325	0.2	-33,375	-4.19
Korean	1,076,872	0.4	1,423,784	0.5	346,912	32.21
Vietnamese	1,122,528	0.4	1,548,449	0.5	425,921	37.94
Other Asian	1,285,234	0.5	2,192,151	0.7	906,917	70.56

Source. ProximityOne 2014; U.S. Census Bureau 2011.

can immigration and population growth in the United States. This section presents a brief historical introduction to the major Asian American groups.

Chinese Americans

The Chinese were the first Asian group to come to the United States. The political unrest and depressed economy in China, combined with the need for cheap labor in the United States, led large numbers of Chinese to immigrate to the West Coast during the gold rush period (1848–1882) (Takaki 1998). The Chinese, mostly men, worked as hand laborers in the mining, farming, and railroad industries. They contributed significantly to agricultural success in California and to the construction of the Union Pacific transcontinental railroad.

The flow of Chinese immigration ceased in the latter half of the 1800s, a period of economic recession in the United States, when cheap Chinese labor was considered a threat to American workers. This threat led to the passage of several discriminatory laws to limit Chinese civil rights and the flow of immigration. The Chinese Exclusion Act of 1882 and several other immigration and naturalization acts that were enacted and enforced for the next 60 years prohibited Chinese from bringing their families to the United States, owning land, and becoming American citizens.

Despite the harsh treatment from the government, thousands of Chinese, along with other Asian groups (namely, Filipino and Japanese Americans), joined the U.S. Army during World War II to prove their loyalty to America. Asian Americans' participation in the war campaign against the German Nazis and Japan led to a more favorable attitude toward Asians in America. The U.S. Congress eventually repealed all 15 Chinese Exclusion Acts in 1943. The subsequent enactment of the War Bride Acts in 1945 allowed many Chinese and Japanese wives of Asian American and American servicemen to come to the United States. During the Chinese Civil War between the Kuomintang and Communists in China in 1949, large numbers of highly educated Chinese students, visitors, and seamen were granted permanent residence in the United States. The political uncertainty and upheaval in China during and after the Cold War continued to feed the flow of Chinese immigrants to America, most notably after the massacre in Tiananmen Square in June 1989. The subsequent crackdown on the democratic movement in China after 1989 also led many Chinese scholars and students to seek political asylum in the United

States. Recently, many Hong Kong immigrants chose to come to the United States because of fears of living under the Chinese Communist regime when the British government returned Hong Kong to China in 1997.

Filipino Americans

Filipino immigration began in the early 1900s with small numbers of seamen and laborers (Arameta 1993; Takaki 1998). More Filipino immigrants came during the second wave, 1906–1934, to fill in as cheap laborers in the farming and canning industries after the Gentlemen's Agreement Act between the United States and Japan limited the immigration of Japanese laborers. The third wave, composed of Filipinos who served alongside U.S. servicemen who fought against the Japanese in the South Pacific, arrived in the United States after World War II. The fourth wave arrived after 1965, when the immigration quota was lifted; unlike previous waves, this group of Filipino immigrants consisted of highly educated professionals such as doctors, engineers, and nurses who fled the depressed economy and the political repression of the Marcos regime. They came with the dual purpose of enhancing their professional skills and filling the employment gap in the United States during the economic boom of the 1960s and 1970s.

South Asian Americans

Asian Indians immigrated to the United States in small numbers during the 1800s (Juthani 1992; Prathikanti 1997). An influx of young Asian Indian professionals occurred during the late 1960s and early 1970s. From 1980 to the present, many Asian Indians who immigrated were computer science engineers and workers who contributed significantly to the boom of the high-technology industry during the 1990s. A large proportion of the new immigrants during this time were family members and relatives of the Asian Indian professionals who immigrated during the 1960s. These family-sponsored immigrants were not as well educated and were unfamiliar with Western culture.

Southeast Asian Americans

Southeast Asian Americans came to the United States not as immigrants but as war and political refugees. At the end of the Vietnam War in 1975, hundreds of thousands of Vietnamese fled the country to escape the Communist regime

(Cima 1989; Ross 1990; Savada 1995). This first wave of refugees included mostly well-educated, high-ranking government and military officers and their immediate families. The second wave arrived from 1978 to 1982 and consisted of Vietnamese, Vietnamese Chinese, Cambodians, and Laotians, who were less educated and were unfamiliar with Western culture. They were “boat people” who risked their lives on rough seas to escape the political, religious, and racial discrimination and persecution of the Communist regimes in Vietnam, Cambodia, and Laos. The third wave of Southeast Asian refugees, mostly Amerasian children of American servicemen and Vietnamese women, concentration/reeducation camp survivors, political refugees, and families of refugees from the previous waves, came after 1985. Southeast Asian refugees, especially those from the second wave, experienced many untold traumas related to their uprooting from war-torn countries and during their escape journey. The ones who made it to the United States faced tremendous challenges adjusting and adapting to American life, resulting in high levels of stress.

Korean Americans

The first significant wave of Korean immigrants came to the United States between 1903 and 1905 (Kim 1993). They were mostly uneducated men employed by sugar plantations in Hawaii. These laborers contributed significantly to the movements to liberate Korea from Japanese colonial occupation. The second wave of Korean immigrants arrived between 1951 and 1964, during and after the Korean War, as wives of American servicemen, orphans, and students. The third wave consisted of Koreans who came to the United States after 1965, when the immigration quota imposed on Asians was lifted.

Japanese Americans

Similar to the Chinese, the Japanese immigrated to the United States in large numbers between 1880 and 1920 (O’Brien and Fugita 1991; Takaki 1998). Many Japanese sought a better life away from the depressed economy during the Meiji era when Japan rapidly transformed from a feudal, agrarian society to a democratic, industrialized one. They worked as hand laborers in sugar plantations, farms, mines, canning factories, and the railroad industry. Unlike the Chinese immigrants, who were mostly men, Japanese immigrants sent for wives from their own country. Many of these women came as “picture brides”

who had not previously met their husbands. Japanese immigrants experienced harsh treatment similar to that faced by other Asian immigrants in the United States. Eligibility for citizenship, owning land, and marriage to whites were prohibited. Many were prevented from obtaining jobs commensurate with their skills. The most traumatic discriminative act occurred during World War II, with the implementation of Executive Order 9066 in 1942 that forced more than 100,000 Japanese Americans into internment camps. The internment camp experience has had prolonged and lasting dramatic effects on this generation as well as subsequent generations of Japanese Americans (Nagata 1991). Today, most Japanese Americans are well assimilated, with more than half married to non-Japanese Americans.

Pacific Islanders

Pacific Islanders are neither refugees nor immigrants. They are the descendants of indigenous peoples on Pacific islands that were claimed and taken by European explorers, missionaries, and colonists. In the late 1760s, Captain James Cook discovered Hawaii, followed by Tonga in 1770. He and his crew brought previously unknown diseases to the natives on these islands, which decimated their populations. Subsequent to these discoveries, missionaries and traders followed to colonize the islands and to impose different religions, cultures, and laws on the islanders. They occupied the islands and took away the islanders' land ownership (U.S. Department of Health and Human Services 2001).

Pacific Islanders are as diverse in language and culture as their islands. They consist of three large groups: Polynesians, Micronesians, and Melanesians (U.S. Department of Commerce, Economics and Statistics Administration, Bureau of the Census 1993). The Polynesians are most numerous and include Hawaiians, Samoans, Tongans, and Tahitians. The Micronesians are the second largest group and consist of Guamanians (or Chamorros), Marianas Islanders, Marshall Islanders, Palauans, and other smaller groups. The third group is Melanesian, mainly from the Fijian population. Hawaii has been a state of the United States since 1959. The other islands remain as free associated states affiliated with the United States. Their people elect their own legislatures and governors, and the U.S. Department of the Interior has administrative responsibility for coordinating federal policy.

Assessment and Therapeutic Techniques: Using the DSM-5 Outline for Cultural Formulation and the Cultural Formulation Interview With Asian Americans

The DSM-5 OCF and the biopsychosocial model are particularly useful to clarify Asian American patients' dynamics, diagnoses, and treatment plans. Culture, religion, and philosophies of life intertwine to shape Asian American health beliefs and health care-seeking behaviors. The DSM-IV-TR OCF, updated in DSM-5 (American Psychiatric Association 2000, 2013), is an excellent tool for cultural assessment. It aids the clinician in evaluating a patient's ethnic identity, cultural explanations of the illness, cultural factors related to psychosocial environment and levels of functioning, and cultural elements of the relationship between the individual and the therapist (Group for the Advancement of Psychiatry, Committee on Cultural Psychiatry 2002; Lu et al. 1995). A thorough psychiatric interview to obtain information for a DSM-5 diagnosis and cultural formulation is necessary to understand the Asian American dynamic, to formulate the case, and to strategize the treatment course.

The Cultural Formulation Interview (CFI) in DSM-5 was derived from the OCF and provides sample questions to ask the patient to obtain the desired history for a cultural formulation. It consists of 16 questions arranged in 4 domains, along with 12 supplementary modules and 1 informant module to help the clinician elaborate a particular area of the OCF. For example, cultural identity is covered in the second domain, "Cultural Perceptions of Cause, Context, and Support," questions 8–10 of the domain's 7 questions. The other domains are the "Cultural Definition of the Problem" (questions 1–3), "Cultural Factors Affecting Self-Coping and Past Help Seeking" (questions 11–13), and "Cultural Factors Affecting Current Help Seeking" (questions 14–16) (see Appendix 1, "DSM-5 Outline for Cultural Formulation, Cultural Formulation Interview, and Supplementary Modules"). The scenes from Video Cases 2 and 4 available at www.appi.org/Lim demonstrate some techniques for using the OCF with Asian American patients, and the use of the CFI (American Psychiatric Association 2013) from DSM-5 is also discussed in the case examples.

Cultural Identity of the Individual

The cultural identity of the individual is shaped by several cultural variables distinctive to that person's ethnicity; age; gender; sexual orientation; socioeconomic status; educational achievement; and philosophical, religious, and spiritual beliefs.

Cultural/Ethnic Identity

Ethnic identity is defined as a person's sense of belonging with other members of the ethnic group and the extent to which that person embraces and practices his or her ethnic cultural tradition (Marsella 1993). Asian American ethnic identity depends on each person's degree of assimilation with or acculturation to American culture. In general, new, recent, and elderly immigrants are very traditional. Immigrants who are from urban areas and well educated in Western culture and younger immigrants who were raised in America can embrace both traditional and American cultures and become bicultural.

Preferred Terms

Most traditional Asian Americans prefer to be referred to as people from their home countries, for example, Chinese American, Japanese American, Filipino American, and Korean American. Subgroups also exist within these immigrant groups. For example, Chinese Americans differentiate among themselves on the basis of their origins in China or their speaking dialects. The most prominent Chinese groups in the United States are the Cantonese, Toisanese, Fukienese, Amoy, Taiwanese, Shanghainese, Hakka, and Szechwanese. In addition to their regionally specific dialects, many Chinese also speak Mandarin, which is the official national language (Gaw 1993).

Southeast Asians (Indochinese) include Vietnamese Americans, Cambodian Americans, and Laotian Americans. Cambodians like to be called *Khmer* because that more closely represents the authentic and original name of people in the country called Kampuchea (the Khmer Empire in the past). The French changed the name Kampuchea to Cambodia during the colonial period, and the term *Cambodian* continues to be used more commonly in the West. Laotians in the United States consist of lowlander Laotians, highlander Hmong, midlander Mien, and Khmu (Cima 1989; Ross 1990; Savada 1995).

Asian Americans who have been in the United States for several generations and have been well acculturated prefer to be addressed as American.

Personal Appearance

Traditional Asian Americans place very high value on the therapist as an authority figure. They expect the therapist to be clean, confident, and organized. Patients are unlikely to show their trust and bring up their problems if the therapist looks untidy or acts improperly (Marsella 1993).

Culture, Spirituality, and Religion

Two distinct civilizations, the Chinese and the Indian, influence most Asian Americans. The Chinese Confucian, Buddhist, and Taoist philosophies exert a strong influence on social, family, and individual values as well as on art, literature, and languages among Japanese, Korean, Vietnamese, Mien, and Hmong societies. The Japanese, Korean, and old Vietnamese (*chu nom*) scripts were derived from Chinese ideographs. The current Vietnamese romanized written language was not developed until the seventeenth century, when French and Portuguese missionaries introduced it for use in evangelism (Cima 1989). The Mien and Hmong have no indigenous written script. They rely on oral history and tradition to transmit their culture from one generation to another. The Hmong use story quilts to keep their history. Their shamans keep their intellectual and cultural records in written Chinese characters (Ross 1990). The Mien language has been romanized to written language since 1982, but use of the romanized Mien language remains unpopular among Mien Americans (Moore and Boehnlein 1991). The Cambodian and Laotian cultures are deeply rooted in Asian Indian civilization. The Cambodian written language is derived from Sanskrit script, and the Laotian language uses Pali script (Ross 1990; Savada 1995).

With regard to religion, most Chinese, Japanese, Korean, and Vietnamese worship their ancestors, follow Confucian teachings, and believe in Mahayana Buddhism. Many Japanese Americans follow Shintoism and Zen Buddhism. Most Filipino Americans are Catholic. More than 70% of Koreans in the United States are Protestant Christians (Kim 1993). Most Hmong and Mien believe in animistic and supernatural causes. Cambodians and Laotians are followers of Brahmanism of Hindus and Theravada Buddhism (Ross 1990; Savada 1995). Among Asian Indians, Hinduism is the major religion (Juthani 1992; Prathikanti 1997). Pakistanis are mostly followers of the Islamic faith.

Hierarchy

Traditional Asian Americans strongly respect hierarchical order in family and society. It is crucial for the therapist to identify and show respect to the person who is head of the hierarchy in order to conduct family or group therapy. Most of the time the elder, grandfather, father, or oldest son makes decisions for the group. In the United States, family members develop different levels of acculturation. The younger member who is bilingual and bicultural or the breadwinner may have more influence in family decision-making matters. Culturally, younger Asian Americans assert their influence behind the scenes to show their respect to elders. The wife will persuade her husband when they are alone. The son will discuss matters with the father separately, not in front of the family. Clinically, the patient may show respect to the therapist by not voicing objections to certain things but then does not carry out fully what has been discussed and agreed on in the session. The therapist should always check in with the patient in a supportive and nonconfrontational manner with which the patient feels comfortable.

Asian Virtues: Modesty, Humility, Politeness

Asian cultures are vastly diverse yet have a common theme of teaching that a person should be modest, humble, and polite. Individuals should put the needs of family and community first and live in harmony with others and nature. One should not speak first in the group out of respect for hierarchy and the virtues of modesty and politeness. Traditional Asian American patients may look shy, passive, and anxious in therapy compared with Westernized patients. They will wait for the therapist to speak and provide guidance. Depending on their level of acculturation, Asian Americans need encouragement to participate in discussions. They express their own opinions when they feel safe and permitted to speak. The degree to which the Asian American patient spontaneously engages in conversation can be used to measure progress in therapy.

Excerpts from an interview with Mr. Chen will help to illustrate many assessment principles with Asian Americans.

Case 1 (Video 4)

Mr. Chen is a middle-aged married Chinese man with depression. He immigrated to the United States to obtain a Ph.D. in electrical engineering and has been unemployed for 2 years. His wife asked him to see a therapist. He was

laid off from his job 2 years ago after working for 4 years since his graduation from his doctoral program. Mr. Chen was irritable and overwhelmed with work and did not get along with his boss. He complained of fatigue, lack of sleep, back pain, and headaches. His primary care physician gave him analgesics. He saw a Chinese doctor, who gave him herbs in a foul-smelling tea, and he had acupuncture, but that did not help. His wife is an employed accountant, and she has a better social network than he seems to have. They have no children. He is the oldest child of two.

In Video 4–1, Dr. Boehnlein explores Mr. Chen's cultural identity by asking about his migration history and his relationships with his family during his assessment of the family history. He discovers that Mr. Chen has a younger brother who is married and has had a son, further cementing his position as the most favored son, which should be Mr. Chen's role. Traditionally, the eldest son is the most favored. Dr. Boehnlein asks Mr. Chen to state where he is from, when he came to this country, and why he came to further assess his cultural identity, following the migration history model. He asks Mr. Chen to describe his relationship with his parents using a migration history, which is part of CFI supplementary module 6, "Cultural Identity," questions 14–22. Mr. Chen is also distressed that he is not fulfilling his gender role as the breadwinner for the family. In Video 4–3, Dr. Boehnlein asks Mr. Chen to describe what adjustments he had to make, including learning in a new language.



Video Illustration 4–1: Migration history and cultural identity (3:42)



Video Illustration 4–3: Cultural adjustment (4:19)

Case 2 (Video 2)

In Video 2–1, Dr. Ton interviews Mr. Tran, a 54-year-old Vietnamese American man with major depression and posttraumatic stress disorder (PTSD). He asks him about his explanation of his sickness toward the end of the interview and acknowledges his fear of being labeled as "crazy." Dr. Ton acknowledges that Mr. Tran's reaction is normal and that good treatments are available. The patient defers to him, saying, "I'm no doctor," and states that he is the expert. Note how Dr. Ton persists in asking the patient to share his explanation, stating that he understands and appreciates Mr. Tran's confidence in him but wants to hear Mr. Tran's perspective because he is the expert on his suffering. At that point, Mr. Tran states that he thinks being exposed to mortar fire during the war caused his suffering because he was one of the few survivors.



Video Illustration 2–1: Eliciting an explanatory model (3:14)

As mentioned earlier, the clinician can use questions 8–10 of the CFI to help an individual to describe his or her cultural identity and how it affects the problem (see Appendix 1, p. 483). Questions 1–34 from supplementary module 6, “Cultural Identity,” can be used to explore the individual’s cultural identity (see Appendix 1, pp. 502–505).

Cultural Conceptualizations of Distress

Asian Americans’ health explanatory systems for illnesses and psychiatric disorders originate from their religious and spiritual beliefs. These beliefs are associated with their expressions of illness and health-seeking behaviors.

Health Beliefs and Practices: Traditional Healing Methods, Spiritual Healing, and Herbal Treatment

Substantial numbers of Asian Americans seek traditional treatment before coming to see Western doctors (U.S. Department of Health and Human Services 2001). The therapist should respect and ask about past and current traditional treatment. This is the opportunity to understand different methods of treatment from different cultures. The sincerity of learning from different points of view will make patients feel that the therapist is empathetic with their struggle to get well. A consultation with the spiritual healer, if necessary, can help to provide holistic spiritual, psychological, and biological care for the patient.

A large percentage of Asian Americans may use herbal medicine concurrently with Western medicine. The interactions between herbs and Western medicine have not been fully studied. Some of the herbs with atropine-like anticholinergic effects can cause anticholinergic psychosis, particularly when used simultaneously with tricyclic antidepressants or low-potency typical neuroleptics. Some of the herbs also interfere with the metabolism of psychotropic medications (Lin et al. 1997). The therapist should obtain an herbal medication history and explain the possible adverse effects to the patient. If there is no danger to self or others, it is prudent to give the patient an opportunity to choose to pursue one kind of treatment at a time to see which one works.

Idioms of Distress and Cultural Concepts of Distress (Culture-Bound Syndromes)

Idioms of distress: somatization. Asian cultures consider emotional expression as personal weakness and highly stigmatize mental illness (U.S. Department of Health and Human Services 2001). With the concept of unity of mind, body, and soul, Asian Americans express their psychological distress mostly by somatic complaints (Lin et al. 1985; Nguyen 1982). Exploring and clarifying somatic complaints helps the therapist understand the dynamics of emotional disturbance and stress. These somatic complaints should be examined and worked up thoroughly to rule out possible medical illness before proceeding with psychiatric treatment and therapy. Even if the results of the somatic workup are negative, the attention to somatic complaints will show the patient that the therapist can provide a total care treatment plan that includes mind and body. This will reinforce the therapeutic alliance and the patient's trust in the therapist.

For example, traditional Asian Americans may show their depression by complaining of severe, constant headaches; muscle aches; joint pains; backache; fatigue; low energy; dizziness; sad eyes; blurred vision; or confused and overwhelmed thoughts. Anxiety can also cause an increasing frequency of urination, constipation, or diarrhea. Frustration, anger, or feelings of disgust can lead to repeated vomiting or complaints of a "hot stomach." It is not uncommon to hear the patient express anger or frustration as "my frustrated *qi* is up to my chest"; these symptoms can cause shortness of breath and breathing difficulty even when a workup for chest pain shows no organic cause. Somatic symptoms tend to be exacerbated at night when the patient has difficulty sleeping and has more time to think about the troubling issues.

According to the belief of integration of mind and body, somatic manifestation can be interpreted as one Chinese patient said: "Depression or distress penetrates painfully to all my muscles, joints, and deep to my bones. The stresses are so much that I feel overwhelmed, unable to think [or] to hear and to see clearly. The distresses are so heavy that I am exhausted of all my physical energy. I feel so weak, barely able to move my limbs" (N. Du, personal communication, 2006)

Cultural concepts of distress. Asian Americans can also have a variety of psychiatric syndromes that are strange to Western culture but are appropri-

ate to their beliefs. These cultural concepts of distress, formerly known as “culture-bound syndromes,” are not discussed in detail in this chapter. More information can be found in Appendix 2, “DSM-5 Glossary of Cultural Concepts of Distress,” and in Table 4–2. The principle of evaluation and treatment is to do no harm and to prevent misdiagnosis and the use of inappropriate medication. Hence, cultural concepts of distress need to be thoroughly evaluated and managed in the context of Asian American health beliefs.

Case 1 (*continued*)

In Video 4–2, Mr. Chen mentions that he thought he was sick because of bad luck and that his family recommended that he see a Chinese doctor, who gave him some foul-smelling herb tea. He also enjoys going to see his acupuncturist and speaking with him. Dr. Boehnlein asks him whom he has seen, and Mr. Chen tells him that he has seen an herbalist and an acupuncturist, but neither helped very much. Dr. Boehnlein asks him about his family history (not shown), and Mr. Chen replies that his mother had *shenjing shuairuo*, or neurasthenia, a DSM-5 cultural concept of distress. If Mr. Chen had not stated the name of his mother’s illness, Dr. Boehnlein might have had to ask him if there was a name for her illness in China.

Video Illustration 4–2: Cultural concepts of distress—shame (8:21)

Religion and Spiritual Philosophies

Religion and spiritual philosophies have a strong influence on Asian Americans’ health beliefs and practices. A brief review of the relation of health issues in religion and Asian cultures is necessary to understand Asian American help-seeking behaviors. A summary can be found in Table 4–3.

Confucianism. Confucianism originated from Confucius (Master K’ung, full name Ch’iu K’ung), a fourth-century B.C. philosopher in China. Confucian teaching developed a standard of a civil code of conduct that has deeply influenced the Chinese and the people in Korea, Japan, and Vietnam. Confucianism emphasizes reciprocity, benevolence, filial piety, respect for authority, self-development, and scholarship. It advocates peace and harmony in society by practicing and respecting a hierarchical order. In the family, a

Table 4–2. Cultural concepts of distress

Syndrome	Country where seen	Characteristics
<i>Amok</i>	Southeast Asia	Acute display of rage or a sudden outburst of aggressive and violent behaviors
<i>Dhat syndrome</i>	South Asia	Severe anxiety and hypochondriasis reaction, often leading to a discharge of semen, whitish coloration of urine, and feelings of weakness and exhaustion
<i>Hwa byung</i>	Korea	Insomnia; indigestion; dyspnea; anxiety or panic attacks; feelings of impending death; and feelings of a mass in the abdomen, somatic pain, or aching
<i>Koro</i>	China and Southeast Asia	Fear that sexual organs and appendages are shrinking smaller into the body, resulting from secondary symptoms of insomnia, restlessness, anxiety or panic attacks, paranoia, or a hallucinative state
<i>Latah</i>	Malaysia, Indonesia, the Philippines, Thailand, Southeast Asia, Japan, and Mongolia	Hypersensitivity to being startled; reaction with echolalia, echopraxis, coprolalia, command obedience, and dissociative or trancelike behaviors
Neurasthenia	China	Feelings of general weakness or fatigue accompanied by a variety of physical and mental symptoms, such as dizziness, gastrointestinal problems, sexual dysfunction, sleep disturbances, diffuse aches and pains, irritability, poor concentration, and memory loss

Table 4–2. Cultural concepts of distress (*continued*)

Syndrome	Country where seen	Characteristics
<i>Qi-gong</i> -induced psychosis	China	Improperly practiced <i>qi-gong</i> can cause severe headache, chest pain, abdominal pain, nocturnal emission, respiratory difficulty, anxiety, hallucination-like symptoms, mood disturbance, memory impairment, and thought disorder, as well as autonomic, primitive, reflective movements, and emotional outbursts such as crying, laughing, shouting, or dancing
<i>Taijin kyofusho</i>	Japan	A variant of social phobia; the patient is self-conscious about his or her own manner, displays unreasonable fear of offending or displeasing other people, and is afraid of direct eye contact, blushing, giving off odor, or having an unpleasant facial expression or a poorly shaped physical feature

Source. Akhtar 1988; Bernstein and Gaw 1990; Caiyun et al. 1988; Huaihai et al. and Shanghai Mental Health Center 1988; Hughes et al. 1996; Kleinman 1986; Lin 1983; Lin 1992; Lin et al. 1992; Ng 1999; Russell 1989; Tseng 2001a, 2001b; Tseng et al. 1988; Westermeyer 1973; Yamamoto 1992.

woman should listen to her father, then to her husband after marriage, and to her son after her husband's death. At the national level, the people should respect the authority of the political leader, the teachings of the teacher, and the orders of the father. The community and familial needs are placed in higher priority than the individual's needs (Huang and Charter 1996). Traditional Asian Americans who follow Confucian teachings consider the therapist an authority figure and a teacher who will give them guidance to relieve their suffering or to help resolve their conflicts. Also, traditional Asian American families and patients deny or hide their mental illness because the bizarre,

Table 4–3. Religious philosophies

Religion	Beliefs	Clinical consequences
Confucianism	Reciprocity, benevolence, filial piety, respect for authority, self-development, scholarship	Elder brother or parents may discourage the patient from taking medications
Buddhism	Human life is full of sorrows due to the family's deeds, one's own karma and expectations, or one's desires.	The patient accepts mental illness in a fatalistic manner and passively does nothing
Taoism or the Way	<i>Yin</i> is the female energy, representing softness, darkness, and coldness. <i>Yang</i> is the male energy, representing strength, lightness, and heat. Balance is achieved by moving the vital energy <i>qi</i> (or <i>chi</i>).	The patient may seek alternative healing methods to balance <i>qi</i>

disorganized, impolite, and disruptive behaviors of the patient or family member in public will bring shame to the whole family.

Buddhism. Buddhism is one of the ancient religions. Founded in India about 2,500 years ago by Siddhartha Gautama, it has spread through China, Korea, Japan, and Southeast Asian countries. Followers of Buddhism believe that human life is full of sorrows and proceeds through stages of birth, age, sickness, and death. Suffering from sorrows does not arise independently but comes through chains of causation resulting from the family's deeds, one's own karma and expectations, or one's desires. To free the self from life's cycle of suffering, one needs to follow Buddha's Four Noble Truths; to do good deeds; and to give up desires, greed, ambitions, and high expectations (Canda and Phaobtong 1992). Asian Americans who practice Buddhism consider mental illness a suffering caused by one's own misdeeds in the past, by too much desire, or by deeds and wills of dead ancestors. Buddhist beliefs affect patients in several ways:

- The mentally ill patient and family feel shame and guilt that inhibit them from disclosing the illness because it could be perceived as indirect proof of wrongdoings in the past. Mental illness thus becomes a stigma of bad karma, and the family and the patient will try to hide or to deny the illness.
- The patient accepts mental illness as a punishment of past karma. The patient follows Buddha's teachings to cultivate good deeds and to lower or extinguish unrealistic desires or high ambitions.
- The patient accepts mental illness in a fatalistic manner and passively does nothing. Mr. Chen (see Case 1) has adopted this approach, as in Video 4–2, and he calls it “bad luck.”

Taoism or the Way. Taoism is a spiritual philosophy practiced and is taught by Lao Tzu and his followers in China. It has strong influence in China, Korea, Japan, and Vietnam. Taoism is the way to achieve a peaceful, content, everlasting life in harmony with nature. According to Taoism, the body is a microcosm of the universe that is governed by the balance of two principal forces: *yin*, the female energy, representing softness, darkness, and coldness, and *yang*, the male energy, representing strength, lightness, and heat. The balance is achieved by moving the vital energy *qi* (or *chi*) from one vital organ or site to another through a complex network of channels (*luo*), meridians (*jing*), and capillaries (*mai*) interlacing the entire body (Reid 1994). The imbalance of *yin* and *yang* or the blockage of *qi* causes illnesses.

The *yin-yang* theory is the foundation of traditional Chinese medicine, which advocates meditation, *tai chi* breathing and body movement exercises, and *qi-gong* breathing exercise that directs the *qi* to the appropriate paths to preserve good spiritual, mental, and physical health. Traditional Chinese treatment uses herbal medicine, food ingredients, or acupuncture to preserve, to improve, or to restore the balance of *yin* and *yang* in the body.

Health Beliefs and Practices

Naturalistic beliefs. Naturalistic theory is a common health belief among Chinese, Southeast Asians, and Filipinos. Health is considered the balance and harmony between the human body and natural forces. Changes in the weather or physical condition of the environment can cause physical and mental illnesses. The theory of “hot and cold” balance energy in the body and among vital organs is very similar to the *yin* and *yang* principles in Taoism.

Eating excessive foods that have too much “hot” or “cold” energy will upset the balance in certain organs and cause illness. Frequent exposure to “bad, cold” wind or a “damp, wet” environment will result in a bad cold, fever, chills, or rheumatism. The naturalistic theory speculates that “bad wind” can penetrate into the body openings such as the mouth, ears, nose, and anal and genital orifices. The body becomes more vulnerable to “bad wind” after surgery, giving birth, or exhaustion caused by overwork or stress.

Several traditional methods of treatment using naturalistic theory common among Asian Americans include coining, pinching, cupping, and moxibustion.

- *Coining* is the practice of using a coin or similar dull-edged object (e.g., silver coin or ceramic soup spoon) to scratch superficially on a certain area on the body until the skin turns deep red (i.e., develops petechiae) to get the “bad wind” out of the body. The deeper the redness on the skin, the more “bad wind” has been released from the body. Coining is applied mostly on the back, along the intercostal spaces on both sides of the spine, or at the back of the neck.
- *Pinching* is similar to coining. The traditional care provider uses fingers to pinch the skin in sensitive areas until a contusion occurs, indicating that the “bad wind” has been removed or released.
- *Cupping* is a method of applying heated cups on the back, forehead, or abdomen to suck out the “bad wind.”
- *Moxibustion* is a method of treatment that uses burning incense or combustible herbs to cause superficial small burns on the torso, head, and neck to remove the “bad wind.”

Animism. Animism is popular among rural Laotians, Hmong, Cambodians, and Vietnamese (Aronson 1987; Westermeyer 1988). Animists believe that human beings, animals, and inanimate objects all possess souls and spirits. Illness is attributed to punishment of the gods, ancestor spirits, evil spirits, or the loss of one’s soul. Traditional treatment involves calling on the assistance of a shaman, who is knowledgeable in discovering the causes of the illness, and then performing specific ceremonies to ask for forgiveness from the gods and/or ancestors and to chase the evil spirits away or call one’s soul back to the body.

Ayurveda. Ayurveda (*ayur*: longevity; *veda*: knowledge) is a medical system that originated from Hinduism. The central concept is that there are three vital humors in the body representing the three cosmic elements in the universe: breath for air or wind, bile for fire, and phlegm for water. Good health is the balance of this triad of vital humors and the harmony of mind, soul, and body with the natural environment and community. Ayurveda is still very popular among South Asians (Juthani 1992; Prathikanti 1997). Traditional therapies aim at keeping or correcting the delicate balance inside the body in harmony with outside forces of nature and conflicts in the community. Proper diet, breathing exercises, meditation, and yoga practices are the traditional methods to enrich the body humors' homeostasis and restore vital energy. Ayurveda's goals are to prevent illness, to treat sickness, and to rejuvenate the body for longevity.

Pacific Islanders' view of health and illness. Native Hawaiians believe that the psyche and the body are inseparable and that good health is the harmonic integration of the person with the natural and spiritual worlds. The disturbance of these balances causes physical or mental illnesses.

Samoans believe in germ theory for certain diseases. They also think that overwork, lack of sleep, exposure to bad weather, or "bad blood" is the cause of physical illness. Samoans value close relationships in their family and responsibility in their community. They attribute serious illnesses to interpersonal conflicts in the family or among friends or to violation of social laws or God's laws (Cook 1983).

In Case 1, Dr. Boehnlein asks Mr. Chen in a later part of the interview (not shown) about his religious background and discovers that he is a Buddhist who believes in karma and that he feels that he does not have much control over his fate. See Table 4-4 for a summary of these health beliefs and practices.

Psychosocial Stressors and Cultural Features of Vulnerability and Resilience

Despite the vastly diverse origins, time of arrival to the United States, degree of acculturation, socioeconomic status, and level of education of different Asian American subgroups, their family structure and developmental pro-

Table 4–4. Alternative beliefs and healing strategies

Belief system	Beliefs	Healing strategies
Naturalistic	Health is considered the balance and harmony between the human body and natural forces. Causes of illness can be changes in the weather, eating excessive foods that have too much “hot” or “cold” energy, frequent exposure to “bad, cold” wind or “damp, wet” environment, surgery, giving birth, or exhaustion due to overwork or stress. Therapy seeks to remove the “bad wind.”	<p><i>Coining</i>: using a coin to scratch superficially on a certain area on the body until the skin turns deep red</p> <p><i>Pinching</i>: using fingers to pinch the skin in sensitive areas until a contusion occurs</p> <p><i>Cupping</i>: applying heated cups on the back, forehead, or abdomen</p> <p><i>Moxibustion</i>: using burning incense or combustible herbs to cause superficial small burns on the torso, head, and neck</p>
Animism	Illness is attributed to punishment of the gods, ancestor spirits, evil spirits, or the loss of one’s soul.	A shaman will perform specific ceremonies to ask for forgiveness from the gods and/or ancestors and to chase the evil spirits away or call one’s soul back to the body
Ayurveda	Three vital humors in the body represent the three cosmic elements in the universe: breath for air or wind, bile for fire, and phlegm for water.	Proper diet, breathing exercises, meditation, and yoga practices are the traditional methods to enrich the body humors’ homeostasis and restore vital energy

cesses share similar traditional values that are rooted in the agricultural and feudal society cultures and in Eastern religion and philosophies.

Family Structure

Asian American families appear to occupy a high place in the socioeconomic structure of the United States. Taken as a whole, they have a higher median household income (\$67,142) than all other U.S. ethnic groups (whites are second on the list at \$54,168) because of a combination of higher educational achievement and having more household members in the labor force. As individuals, the average per capita income of Asian Americans is higher than the national per capita income, with a median individual income of \$44,577, with the next group being Native Hawaiian and Pacific Islanders at \$37,791, followed by whites at \$34,669 (Fairfax 2012). These statistics show that even in the United States, Asian Americans continue to remain in extended-family households where several generations live together under the same roof.

In a traditional extended Asian family, the hierarchy of authority is very important and is established according to age, sex, and order of birth. A male elder, usually a grandfather, father, or oldest son, assumes responsibility as the breadwinner and protector of the family; he makes most of the important family decisions. The older children are expected to have more responsibilities in helping their parents and in caring for younger siblings. Family members are interdependent and supportive of each other until an individual becomes self-sufficient. The family structure mirrors the teaching of filial piety, which expects children to obey and respect their parents and elders and to provide care for their parents in their old age (Lee 1996). It is common to see the adult Asian American settling down near his or her extended family to maintain family ties and provide support to other siblings and their parents. The degrees of acculturation and education of family members affect how the traditional family evolves to adopt different values in Western culture. In Video 4–2, Mr. Chen mentions his shame at not being able to support his family. In a later part of the interview, Mr. Chen states that he is also ashamed that he cannot afford a house and that his parents cannot visit. The CFI offers some questions in supplementary module 3, “Social Network,” in which the key persons in a patient’s life and their roles in the patient’s illness are identified. In the case of Mr. Chen (Video 4–2), these persons include his friends and family, who rec-

ommended that he seek Chinese medicine or acupuncture for his problem (see Appendix 1).

Intergenerational Conflicts

Clinically, examples of intergenerational conflicts are evident when parents enforce strict traditional values while children adapt to American values of individualism, autonomy, assertiveness, and open communication. These conflicts are seen most often in adolescents, as we discuss later in this chapter. Intergenerational conflicts are much less pronounced in families with parents who have been well acculturated or assimilated to American culture or in Asian American families that have been in the United States for several generations. Recently, there has been an increase in the number of successful Asian American interracial families. Family problems can arise if there are conflicts about different racial and cultural values, communication styles, and child-rearing issues (Crohn 1997; Lee 1996).

Developmental Issues

Asian American children. Although traditional Asian American families prefer male children because they can carry on the surname of the family, highly acculturated and bicultural Asian American families value both male and female children equally. In addition to the parents, other extended family members play a prominent role in providing love and caring for the child. In return, children are taught to respect and listen to the elders in the family and to keep the tradition of filial piety. Children learn to honor the family's name by showing good behavior in the family and community. Values such as high achievement, hard work, responsibility, obedience, respect, and filial obligation are encouraged and praised. Problematic behaviors such as aggression, antisocial behaviors, disobedience, irresponsibility, and poor performance in school bring shame to the family. Modesty is encouraged, to the point that even though Asian American parents are proud of their children's academic achievement, they rarely praise them directly. Thus, children are taught to be humble instead of arrogant; the rationale is that the fewer the praises, the harder the children will strive for higher achievements. Such traditional expectations by parents living in the United States bring tremendous stress to Asian American children. Fear of failure, starting with academic failure at an early age, leads to guilt, shame, self-blame, and low self-esteem (Chung 1997).

Asian American adolescents. During adolescence, Asian Americans often face the double stresses of living up to family traditional expectations at home and having to adapt to Western cultural values at school. These diverging cultural expectations can cause identity crises for youths. Examples of possible reactions to these dual stresses include 1) marginalization and alienation from both Asian and American cultures, as seen in some gang members; 2) withdrawal into Asian culture and rejection of the American culture; and 3) acculturation to American culture and rejection of Asian traditional values. Adolescents who are able to overcome these stresses and integrate well into both cultures will eventually become the liaison for the family with the outside society. Parents depend on these children to provide interpretation and assistance to obtain health care, welfare, and social supports. This role reversal not only gives the children who are bilingual or bicultural more participation in family decision-making processes but also puts more burdens on the youth in addition to the stresses of growing up and obtaining an education. Asian American adolescents who are able to speak their native language fluently to communicate with their parents show high self-esteem and respect to their parents (Boutakidis et al. 2011). Asian American college students who acculturate well into Western culture and values show less psychological distress (Ruzek et al. 2011). Often, conflicts and stresses in attempting to adapt to both cultures can result in poor academic performance, dropping out of school, using drugs, joining a gang, or running away from home (Huang 1997).

Special attention should be given to Southeast Asian children who have experienced the trauma of forced labor, starvation, uprooting, separation, and loss of family. These Southeast Asian children and adolescents show a high prevalence of depression and PTSD symptoms, making the acculturation process particularly challenging for them and their families (Kinzie et al. 1986, 1989; Sack et al. 1996).

Asian American young adults and adults. Asian American young adults face the stress of compromising personal independence and family obligation. Besides having high academic achievement expectations, they must make a career choice, build a social life, choose their friends and partnerships, and find a marriage partner. In addition, they face stress caused by racism and discrimination in school and at work (Wong and Mock 1997). Asian American refugees and immigrants who are unable to speak English when they come to the

United States need about a decade to adjust psychologically to American life and values (Tran et al. 2007).

Asian American elderly. Traditionally in Asian society, the elderly are respected for their lifelong contributions to the family and community as well as revered for their life experiences. The family and community take their words of advice very seriously. Although old age is associated with conservatism, non-creativity, nonproductivity, and dependency in America, it is regarded as a sign of distinction, deserving of respect, in Asian culture; hence Asian American adults continue to seek the advice of the elderly, even those far advanced in age.

Attention should be paid to Asian Americans who came to the United States in the 1920s to work as railroad and mining laborers, who faced the greatest amount of brazen racism and discrimination. They tended to live in ethnic Chinese enclaves well into their old age, without adequate health care and welfare support (Chen 1976; Kao and Lam 1997). Those Asian Americans who came to the United States in the late 1900s brought along their children. As their children grew into adulthood, they become more acculturated and served as intermediaries in helping their elderly parents adjust to Western culture; issues of intergenerational gap are less prominent among this group. In contrast, Asian American elders who were sponsored to come to America by their immigrant children often find the intergenerational gap too wide to bridge, and traditional expectations clash with Western values on a regular basis, leading to stress on both adult children and elderly parents (Kao and Lam 1997).

Gender Issues

Asian American women. In most Asian societies, women have a lower status than men. Asian women often assume responsibilities for domestic affairs, providing love and caring for the whole family. They are expected to be modest, supportive, and protective. Women sacrifice their personal needs for the success of their husbands and children. Asian American immigrant women face a host of cultural challenges that can lead to stress. In addition to the stress of learning a new language and culture, many women work outside the home to support the family financially. Exposure to Western values of independence and individual rights, along with their discovery of self-worth, can lead them to be more confident and outspoken in the home. These values often clash with Asian traditional values, particularly when women are the main bread-

winners for the family, essentially reversing roles with the men. The role reversal may cause a shift of domestic power and a strain in the marital relationship that can lead to domestic violence (Homma-True 1997; Masaki and Wong 1997). In Case 1, Mr. Chen feels that he is not fulfilling his gender role as the breadwinner and is ashamed that he is not working, stating that his wife should cook and that he should work. The power shift that he is experiencing is totally opposite from what is expected of him as a Chinese man.

Immigrant women from Southeast Asia who have experienced uprooting from their countries, death of family members, separation, abuse, and other kinds of war trauma face tremendous adjustment problems. Severe, chronic PTSD and depression are particularly pronounced among this group (Rozee and Van Boemel 1990). Native-born Asian American women do not have to deal with the stress of cultural adjustment; nevertheless, they still have to struggle with racism, sexism, and discrimination on a daily basis. They have to overcome the dual negative stereotypes of being submissive, passive, helpless, and obedient and being the “dragon lady” who is evil and untrustworthy. Cultural differences and stereotypes lead to many problems for Asian American women who have interracial marriages, particularly in issues related to communication, child rearing, and coping with in-laws (Homma-True 1997).

Gay and lesbian Asian Americans. Homosexuality has been documented in Chinese, Japanese, Filipino, and Asian Indian literatures, but the concept of same-sex relationships has been discouraged in all Asian cultures (Nakajima et al. 1996). Homosexuality is considered to go against several Asian religions and philosophies. A same-sex relationship does not fit into Confucian family hierarchical order and traditional gender roles in society. A traditional Asian woman is supposed to get married and bear children. Traditional expectations for an Asian man, especially an eldest son, are to get married and have children, especially sons, to carry on the family name. Asian American gays and lesbians face tremendous parental pressure to fulfill their traditional roles (Aoki 1997). A homosexual relationship is considered to be a breach of the harmony balance of *yin* and *yang* in Taoism, sexual lust in Buddhism, and a sin in some denominations of Christianity. Traditional Asian parents often make gay and lesbian children feel guilty about their sexual orientation. They disapprove of homosexual lifestyles and consider a same-sex relationship a shame to the family's name. Gay and lesbian Asian Americans face tremendous ob-

stacles in overcoming family bias and traditional societal discrimination against “coming out” (Nakajima et al. 1996).

Cultural Features of the Relationship Between the Individual and the Clinician

Stereotypes, cultural health beliefs, and culture-based role expectations can influence the interaction between the patient and the therapist, regardless of cultural similarity. The use of the biopsychosocial model as a standard therapy model needs to be tailored appropriately to patients from Asian cultures to provide effective treatment.

Expectations of Mental Health Practitioners

Assimilated Asian Americans tend to seek mental help at earlier signs of distress than do traditional Asian Americans. Most traditional Asian Americans and their families seek advice from elders in the family or in the community or from friends or relatives and look for traditional treatment first. They seek Western health care as a last resort, when the patient shows inappropriate or dangerous behavior problems or the family is unable to care for him or her. Often they hesitate to get help sooner because of the stigma of mental illness, as well as fear that Western medications are too strong and not as “natural” as herbal medicine (Tracey et al. 1986; Westermeyer et al. 1983; Ying and Miller 1992).

Most traditional Asian American patients who have made the decision to come to the clinic or hospital expect to get treatment with medication. However, therapists must consider several cultural issues in the psychopharmacological treatment of Asian American patients, especially recent immigrants and those who remain closely tied to traditional health practices. Traditionally oriented Asian patients expect medication to relieve their symptoms in a short time. Psychotropic medications will not be considered as “good” medication unless there are immediate therapeutic effects. Thus, it is important to explain at the beginning of treatment that psychotropic medications take several weeks to build up and exert their maximal effect. The psychiatrist should also tell the patient which target symptoms could be expected to improve. Involving the patient in understanding the treatment and monitoring the target symptoms will increase the patient’s feelings of control and participation and assist in the patient’s adherence to the treatment.

Traditional Asian American patients believe that Western medicines are synthetic chemical substances or pure essence of herbs that are too strong for their smaller bodies and can cause severe side effects. Several studies have shown that Asian Americans require lower doses of antipsychotics and antidepressants to achieve therapeutic effects (Lin and Finder 1983; Lin and Shen 1991; Lin et al. 1989, 1993). The average textbook dosages can be too large and can cause severe side effects. Patients or family members will often reduce the dosage or stop the medication if the patient experiences uncomfortable side effects. To avoid unnecessary side effects, the initial dose should be as low as possible, then it should be slowly and gradually increased until therapeutic effects are obtained. To ensure adherence with treatment, the most common side effects of the medication should be explained clearly at the patient's level of understanding. Incorporation of cultural beliefs, such as "hot and cold" theory, in the explanation will greatly increase the patient's trust and compliance.

Traditionally oriented Asian American patients think of psychiatric pharmacotherapy as similar to medical pharmacological treatment. They expect immediate alleviation of psychiatric symptoms and eventually a cure of their illnesses. They will stop taking the medication when their psychiatric symptoms have improved. It is important to explain to patients the chronic nature of mental illnesses and the need for long-term treatment and follow-up. The clinician should discuss in an open manner the limitation of current psychopharmacotherapy in the treatment of mental illnesses and encourage participation in other psychosocial treatment modalities that can provide additional improvement of symptoms. See Table 4–5 for a summary of medication beliefs that could lead to nonadherence and strategies to address them.

Psychosocial approaches are quite strange to traditional Asian Americans, who rarely hear of "talk therapy." Because of the cultural differences, traditional Asian American patients find it difficult to believe that their symptoms will be improved by talking out their problems. They see their therapists as having different expectations than typical Western psychotherapy goals.

- They respect the therapist as an authority figure, a knowledgeable expert who can understand their physical and emotional disturbances on the basis of an examination, laboratory tests, and verbal and nonverbal expressions without much detailed questioning.

Table 4–5. Common Asian American beliefs about medications and strategies

Traditional belief	Strategy to approach belief
They are too strong	Prescribe small doses
They should act immediately	Inform about duration of effect
They are not needed after the symptoms are gone	Inform of chronic nature of illness
They are not “hot” or “cold”	Explain by using terms <i>hot</i> or <i>cold</i>

- They expect the therapist to make an accurate diagnosis of their problems and then suggest a clear, reasonable course of treatment for them and their family to follow. They will doubt the therapist’s capability if the therapist, out of respect for individualism and freedom of choice, keeps asking them, “What do you want to do?” because their thought process is that “I sought help from you as a last resort, and if I knew what to do, I would not come to therapy to seek help.”
- They expect the therapist to act as an authority figure who has power to judge and to solve their interpersonal conflicts or family problems.
- They expect the therapist to provide information and to advocate for their social welfare entitlements.

In Case 1, Mr. Chen shows that he is concerned about stigma.

Case 1 (continued)

Mr. Chen states at one point that his doctor asked him to get counseling, but he refused because he was not “crazy.” In a portion of the interview not shown, Mr. Chen becomes impatient with his psychiatrist because he is irritated by the many personal questions but also wants an answer to his unspoken question, “What is wrong with me?” He is expecting a quick resolution of his symptoms and feels that the interview is not giving him what he needs at this time. Dr. Boehnlein helps Mr. Chen to feel better about the interview by reflecting back to him what he has heard. This technique is useful at the end of the interview as well because it shows the patient that the therapist is listening.

Knowledge of Asian Americans' health beliefs and expectations can lead to a more culturally appropriate approach, which increases the likelihood of patients' involvement and the maintenance of their treatment.

Clinical Methods

Initial contact. Most traditional Asian Americans present themselves as polite, anxious, and shy in the first contact. To show respect for the authority of the therapist, they will wait quietly and patiently for the therapist to initiate the session. They will rarely ask questions because they expect to be under the care of a capable expert who can understand their problems and provide suitable treatment. A limited, self-revealing introduction of the therapist's credentials, experience, and familiarity with the patient's life experiences, situation, or problems can help to gain the patient's trust in therapy. In the initial session, the therapist should educate the patient about the medication treatment course and therapy process and encourage the patient's participation. A calm, gentle, and supportive approach will put patients at ease and build up the therapeutic alliance for successful later sessions.

Styles of communication. Asian Americans' styles of communication are very diverse. Well-aculturated Asian Americans can be more direct, whereas traditional Asian Americans tend to use more metaphors and nonverbal communication.

Verbal communication. Verbal communication is crucial in counseling and psychotherapy. Asian Americans' verbal communication styles are strongly influenced by their cultural practice of hierarchy, modesty, and harmony in life. Communication style is correlated to their level of assimilation and acculturation.

Listening. Asian cultures do not encourage individuals' overt expression of thoughts and feelings. Thus, a patient showing feelings could be interpreted by traditional Asians as having weakness or a loss of self-control. Traditional Asian Americans listen to their elders in the family and to authority figures in their community. They are modest in voicing their opinions when being asked by others, particularly when asked by those who are more senior or have higher status. In therapy, traditional Asian American patients revere the authority of the therapist and consider the therapist an expert with pro-

found wisdom and high education. Often, they tend to respond passively to questions rather than actively expressing their feelings or complaining about their discomforts. Instead of directly telling the therapist their problems immediately, they expect the therapist to ask the proper questions and to address their problems. They show their respect by using a low voice to answer the therapist's questions. Hence, the therapist's gentle and empathetic speaking tone and nonconfrontational approach will help patients to feel at ease and secure in therapy.

Silence. Asian tradition teaches individuals to live in harmony with nature, with family, with community, and in interpersonal relationships. Confrontation is discouraged, especially with authority figures and in public places. Disagreement or embarrassment should be expressed discreetly or in some cases through a mediator. Contrary to Western communication, in which no objection means agreement, the traditional Asian American patient's silence can be a nonconfrontational way of expressing disagreement. The therapist should be gentle and patient in exploring the patient's stance on the issues on which patient and therapist disagree.

Metaphors. Although the use of metaphors exists in both the West and the East, Asians place a particularly strong emphasis on the use of literary metaphors, fables, fairy tales, religious stories, and ethical scenarios to teach people culturally appropriate conduct and ways of life. These metaphors are further enforced by a history of strong oral tradition that passes these stories from one generation to another. To apply these Asian stories as an analogy to clarify the patient's conflicts and to suggest guidance is an effective method for communicating with Asian patients in an indirect and nonconfrontational way.

Nonverbal communication. To traditional Asian Americans, nonverbal communication is as important as verbal communication. Nonverbal behaviors are used to express emotions, feelings, and thoughts discreetly and politely without showing weakness or confrontation. Here are two examples of common nonverbal communication among Asians:

- **Eye contact:** Direct eye contact is considered disrespectful to another person who is at equal status or of higher status and authority because it conveys a message of challenge. Asian parents use a stare or a stern glance to

express their disapproval or disappointment to their children in public instead of verbally scolding them. In therapy, traditional Asian Americans will avoid eye contact to show respect to the therapist. They will glance occasionally toward the therapist to indicate interest and attention to the conversation. The use of intense staring at an Asian American patient can cause feelings of anxiety, fear, and discomfort.

- **Physical contact:** To show their respect for hierarchy and authority, Asian American patients keep some distance from the therapist. A gentle gesture of the therapist to invite the patient to take a seat is enough to make him or her feel at ease. A young patient will politely wait for the therapist to sit first. The therapist should show respect to elder patients by insisting that they be seated first. Shaking hands as a Western gesture of greeting sometimes makes traditional Asian Americans feel uncomfortable; it is more acceptable to male than to most female Asian American patients.

Biological treatment approach. Traditional Asian Americans who take herbal medicine consider Western biological treatment methods unnatural and too potent. To ensure a culturally appropriate biological approach, the therapist should acknowledge the patient's concerns about the strong effects of the Western medication. The therapist should explain to the Asian American patient how the medication might improve and change the chief complaints or target symptoms but that results will not be immediate and may take weeks. The medication should be started at the lowest dosage and gradually increased to a therapeutic dosage to avoid overdosing and unwanted side effects. Information about side effects should be given to the patient and discussed at his or her level of understanding. The therapist should suggest measures that help patients to cope with uncomfortable side effects. Incorporating the patient's health beliefs, such as "hot and cold" theory, in explanation of the medication and side effects will increase the patient's trust of and adherence to treatment recommendations. The therapist must pay attention to somatic pain complaints and provide an appropriate workup and symptomatic treatment to relieve the symptom temporarily while waiting for the psychotropic medications to take effect. When the patient has improved, the therapist should remind the patient to continue with medication because of the chronic nature of mental illness.

Case 3

Mr. N. is 51-year-old Vietnamese American man who was given diagnoses of major depression and PTSD. He had been seen by several clinics and doctors but did not stay in treatment for long with anyone. He described several years' history of depressed mood, insomnia, muscle aches, joint pain, backaches, general weakness, feeling cold, poor concentration, and low energy. He has been unemployed for 12 years since he and his family settled in America. His wife reported that he wakes up at night because of vivid nightmares of a scene of atrocities in concentration camps or combat. He hears the sounds of guns, airplanes, Communists shouting, and dead soldiers and friends; however, he told no one because he was afraid that they would think of him as "crazy." The patient believed that "cold wind" had infiltrated his body because while in the army, he frequently slept on the damp, wet ground, and while in the concentration camps, he had to do hard labor and did not have enough clothing to keep him warm. After evaluation, the therapist explained his findings and treatment as follows:

"Mr. N., I agree with your belief that your symptoms are probably caused by severe bad 'cold wind or energy' that has been penetrating into your body for so long. Your symptoms are caused by what we call PTSD and major depressive disorder. It is very fortunate that you survived your battles in the war and the Communist concentration camps. However, these horrible experiences in the war and the concentration camps can have a forceful effect and cause traumatic shocks to your brain and mind. You must have been very strong to survive for all these years to bring your family to America. Now you and I have to fight these symptoms together. I am going to prescribe to you a low dose of risperidone to reduce the voices and noises and gradually make them go away. I will give you paroxetine to make you feel less depressed, have more energy, and be able to concentrate better. I will also give you trazodone to help you sleep better at night. When you have a headache, muscle ache, or backache, you can take acetaminophen for pain. The medications that I give you have 'hot energy' qualities [most anticholinergic effects are considered 'hot energy' qualities]; they may cause dry mouth, constipation, dizziness, and palpitations. You will need to drink a lot of water to counteract these effects and to help the 'hot energy' spread throughout the body. The 'hot energy' medications are good for you because they will balance the 'bad, cold energy' that caused your illness. I can assure you that you are not 'crazy.' Your illness can be treated, but it requires patience and perseverance. I wish I had the 'magic pills' that work immediately, but our science has its limitations. The medications that I give you will work but slowly. It takes 4–6 weeks or longer to see their maximal effects. You will see the effects of the medication to help you sleep better in 3–4 days, but your mood and other symptoms will take a longer time to improve. Please be patient with yourself and with me. We will work together to

monitor your symptoms closely and to adjust your medication dosage carefully to prevent unnecessary side effects. I will see you again in 2 weeks, but please call me if you have any concerns about your medication or illness."

Mr. N. told his wife that he thought the "doctor of the head" had been able to understand his illness. He was glad to know that he was not "crazy" because that thought has bothered him for so long. He took his medication daily and kept his return appointment 2 weeks later.

Psychological approach. Western psychodynamic concepts have been found to be foreign to traditional Asian concepts of medicine in which mind, body, and soul are inseparable. Western psychology, based on Western culture, emphasizes individualism, freedom of choice, and mastery of nature. Asian culture emphasizes the values of the extended family group, acceptance of one's own fate due to one's karma, and living in harmony with nature (Kinzie 1978; Kinzie and Fleck 1987). Furthermore, traditional Asian virtues of self-control and humility and the concept of loss of face (loss of reputation) to self and family make it difficult for Asian Americans to talk about their mental problems. Because of these differences, traditional Asian Americans find it hard to disclose their conflicts and difficult to believe that "talk therapy" will relieve their symptoms or help to solve their problems.

Several methods of therapy have been proposed to work with Asian Americans. Hsu and Tseng (1972) suggested a problem-solving approach, Kim (1983) advocated for an Ericksonian hypnotic framework, and Tang (1997) advised psychoanalytic psychotherapy. Asian Americans may also be able to participate in cognitive-behavioral therapy (CBT) for the treatment of PTSD, as described by Hinton and Otto (2006). They developed a modified CBT for Cambodians who conceived of their illness as being caused by "bad wind" or muscle tension or dizziness, which may have been caused by forced labor, chronic starvation, and sleep deprivation experienced in the killing fields. *Wind* is thought of as a source of energy flowing through the body. A loss of wind, signified by tension in a joint, leads to bad health outcomes, such as the death of the limb away from the tension due to the lack of blood flow and to the dangerous ascent of wind and blood in the body into the trunk of the body. The patient's catastrophic cognition would be that this wind could cause a heart attack, the person's breathing to stop, or rupture of the blood vessels in the neck or into the head, leading to fainting, blindness, or death. Treatment for the "bad wind" would be cupping (causing redness on the skin by

applying negative pressure through a heated glass bulb applied to the skin) or coining (using coins to rub the skin). In the adapted CBT protocol, the therapist uses the metaphor of the “Limbic Kid” to explain the automatic responses and thoughts associated with the catastrophic cognitions (Otto and Hinton 2006): Cambodian patients receiving CBT are taught that the limbic system is an automatic part of the brain that responds to danger and cannot distinguish between real danger and memories. The patients are told that they must be the parent to the “kid” to comfort it when the danger is not present. The therapist then induces dizziness in the patient by having him or her play a Cambodian childhood game called *hung*, in which the patient holds his or her breath while running to retrieve a stick, experiencing dizziness but no other ill effects, which allows a disconnection of the physical sensation from catastrophic cognitions. Finally, the CBT therapist incorporates a Buddhist ritual, the three bows, with three statements. With the first bow, the patient acknowledges the pain that he or she has experienced. With the second bow, the patient accepts that pain has lingering effects. With the third bow, the patient returns his or her focus to the present and plans to have a good life now.

Asian Americans can benefit from a combination of different approaches if therapists are able to flexibly apply traditional Asian health beliefs and philosophies of life in therapy. At the early stages of therapy when the patient finds it difficult to open up to a stranger, it is appropriate to use supportive, problem-oriented therapy in which the therapist is actively engaged in identifying the problems and providing support and guidance in solving conflicts. This approach matches the Asian American patient’s expectation that the therapist will be an authority, expert, and teacher. The therapist should work to build a therapeutic alliance and trust to allow deeper exploration of interpersonal or family conflicts. Then, the therapist will have the flexibility to take a directive approach to provide psychoeducation and to teach the patient certain cognitive-behavioral techniques for correction of maladaptive behaviors. The use of Asian cultural relaxation techniques that advocate integration of body and mind are familiar and readily accepted by Asian Americans. Culturally accepted methods such as sitting meditation or walking meditation, yoga, *qi-gong*, and *tai chi* exercises are very helpful to reduce stress, anxiety, and depression. Gentle inquiries to clarify the conflicts in a nonjudgmental and nonconfrontational manner will help to stimulate the patient into gaining insights without feeling embarrassment or shame. The therapist can use an indirect

approach that involves metaphors, fables, Buddhist or Zen religious stories, proverbs, or sayings from Confucius and ancient sages to stimulate thinking or to unearth unconscious conflicts. The technique and art of teaching by using metaphors and stories to “wake up” the students’ unconscious thoughts and help them reach enlightenment have been widespread in Asian religious, literary, and philosophical training.

The following two Zen stories are used to show different patients that their thoughts affect their mood and actions. The message in the first is that if the patient can free his thoughts, he can achieve peaceful emotion. The message in the second implies that if the addict wants to get help, he has to make his own decision and be willing to reach out for treatment.

Case 4

Mr. Y. is a 49-year-old Chinese American man who has a diagnosis of bipolar affective disorder and has been stabilized on lithium for several years. However, he feels irritable and becomes easily angered at home and at work whenever someone does or says things that he dislikes. He takes trivial matters personally and feels miserable, angry, and upset for a long time. His therapist offers him the following Zen story to help him let go of his unpleasant emotions.

“One morning after the spring rain, two Zen monks took a walk out of the temple to enjoy the fresh air and beautiful scenery. On their way, they saw a pretty young girl, lovely in a new light pink kimono. She looked anxious and hesitant by the street that had become muddy after the rain. One monk asked her what was wrong and whether he could help. She replied that she would like to cross the street but was afraid that she would ruin her new kimono. He offered to carry her to the other side of the street. With her consent, he lifted her up and held her in his arms to walk across the street. The girl thanked him and happily hurried on her way. Both monks went on to enjoy the spring scenes and sounds.

“After more than an hour, the other monk seemed very annoyed and could not hold his disturbing thoughts any longer. He asked, ‘Brother, I have been thinking about what happened. We are not supposed to touch women. How could you hold her in your arms?’ His friend turned to him and said: ‘Oh, brother! While I think you have been enjoying the smell of fresh air, sounds of birds, scenes of flowers, green grass, and beautiful butterflies on our walk, you have been preoccupied with unpleasant thoughts. I did a good deed to help a little girl. My mind is clean and happy. You see, I put her down one minute after we crossed the street, but you have carried her in you for more than an hour!’”

The therapist's interpretation could be stated as "I hope you will think about this story whenever you think that someone or something made you angry for a long time because it isn't them but rather your prolonged preoccupation that has disturbed and bothered you."

Case 5

Mr. P. is a 25-year-old Chinese American male student who was referred to therapy for his drug abuse problems. The therapist tells him the following story to imply indirectly that the patient needs to be responsible for his treatment.

"Once, there was a young man who accidentally fell into an abandoned well. He yelled loudly for help. The villagers ran over and formed a human chain to rescue him. They were short just an arm's length of reaching him. They called him to extend his arm to grasp the hand so they could pull him up. If he reached out to them, he would live, but if he waited until they could reach him, he probably would have to wait forever and would be dead."

For this story, the therapist's interpretation could be stated as "Do you see that your family, relatives, and friends all want to help you? Now it is up to you whether to grasp their hands or not."

Asian Americans, especially Southeast Asians who have PTSD, cannot tolerate confrontational insight-oriented therapy, which can increase anxiety and exacerbate PTSD symptoms. Research from the Indochinese Refugee Clinic in Oregon (Kinzie et al. 1980), Indochinese Psychiatric Clinic in Boston, Massachusetts (Mollica and Lavelle 1988), and New South Wales Service for the Treatment and Rehabilitation of Torture and Trauma Survivors in Australia (Reid et al. 1990) showed that Asian PTSD patients benefit from a multimodal, supportive, activity-oriented combination of individual and group therapy. Asian American patients with PTSD will feel safe and less anxious in supportive, cultural, activity-oriented groups in which they can relate to others who encountered the same traumatic experiences and have similar PTSD symptoms. Working together on small projects where they can feel worthy, contribute to the group, and be productive will help their self-esteem. The safe and empathetic environment of activity-oriented groups facilitates verbal communication among group members, who can safely recall their trauma and express their suffering under the supervision and guidance of group therapists.

Social approach. In Asian cultures, the individual is closely tied to family and community. Thus, the involvement of family and use of supportive community resources are critical in therapy.

Family involvement. In a family meeting, the therapist should identify the authority figure or the decision maker in the family, who will most likely be an elder, father, or oldest son. Gaining trust from the decision maker is crucial in asserting the therapist's authority appropriately in conducting the meeting. Lee (1997b) proposed a structured, time-limited, problem-solving psychoeducational approach to solve family conflicts, to help the family understand the patient's symptoms and needs, and to provide information to the family about community resources.

Community support. Social support in the community is very important for the Asian American patient and family. The Chinese have created several support systems based on the same language dialect (e.g., Hakka Association, Fukienese Association) or the same surname (e.g., Yee Association, Wu Association, Lee Association). The Vietnamese have organized mutual associations of people who came from the same province or school alumni association. The Laotians and Cambodians have developed their support systems around their Buddhist temples (Canda and Phaobtong 1992). The Protestant Korean and Catholic Vietnamese have relied on their churches for support. Therapists should encourage patients to go to temples or churches and to participate in cultural activities, traditional holidays, and ceremonies. These activities help patients gain a sense of belonging, regain social functioning, and increase the meaningfulness of their lives.

Therapy Issues and Stereotypes

Working with Asian Americans requires an understanding and respect of their ethnocultural and health beliefs. Several therapy issues and stereotypes need to be considered in therapy.

Ethnic psychopharmacology. Recent pharmacokinetic and pharmacogenetic studies on the enzyme system of cytochrome P450 (CYP) polymorphism show that some Asian Americans are slow metabolizers of psychotropic medication because they have low amounts or a deficiency of enzyme activities, mostly of isoenzymes CYP2D6 and CYP2C19. This leads to a high se-

rum concentration of psychotropics in some Asian Americans and can cause severe side effects. This issue is discussed in detail in Chapter 11, “Ethnopsychopharmacology.”

Taboo issues. Asian Americans do not want to reveal problems of the group members to outsiders. They practice tolerance and nonconfrontation to live in harmony with others. The therapist needs to be cognizant of several unspeakable issues because the patient will not bring them up spontaneously.

Family conflicts. Family members suppress family conflicts to save the face and name of the whole family. It is more difficult to bring up conflicts if they involve elders—for example, those between wife and mother-in-law, children and parents, or wife and husband.

Intergenerational differences. Asian Americans acculturate at a variety of different rates depending on their current age, age at arrival, how long they have lived in the United States, socioeconomic status, family structure, and level of education. In general, the younger children learn a foreign language more easily and acculturate faster. The wife may need to go out to work to support the family while her husband struggles to find a job. Elders who come to the United States to reunite with their children’s family may still keep all the traditions of the old countries, which are quite different from the children’s and grandchildren’s experiences in America. Highly educated individuals may have more advantages that help them to acculturate faster. Different levels of acculturation can create role reversal in the hierarchy. The grandfather or father might depend on the grandchildren or children for support and connection to outside communities and resources where the family can obtain social, economic, and legal assistance. Husbands might depend on wives who have become the principal breadwinners for the family.

Domestic violence. Domestic violence is common and is tolerated in several Asian cultures. A generation gap, the stress of adaptation, and role reversal can easily break the husband’s tolerance. The wife and children can become scapegoats and hence the objects of domestic violence. Domestic violence can be carried out psychologically by verbal abuse, threats to harm, intimidation, and degradation or physically by hitting, beating, and keeping family members hostage in the house. In some cases, the husband’s entire family abuses the wife

and treats her as a domestic slave. The family or the husband essentially holds the children “hostage” and keeps the wife’s identification and passport to prevent her from leaving. Families have kept domestic violence as a family secret for fear of shame, losing face in the community, and criminal repercussions (Masaki and Wong 1997).

Homosexuality. As discussed earlier in the “Gender Issues” section, it is very difficult for the Asian American patient and family to bring up homosexuality issues in therapy. Asian American gays and lesbians and their families need tremendous support to come to terms with same-sex relationships and lifestyles (Nakajima et al. 1996).

Youth delinquency. Asian Americans value their children and place great value on their education. Teaching of the children is the responsibility of the entire extended family. Youth delinquency goes against the family teaching and hierarchy and causes pain and shame to the extended family. The family might consult elders to enforce discipline and mobilize relatives to “reform” the delinquent. Having the adolescent go to counseling or therapy is the last resort. Asian youths often join an Asian gang in search of a substitute for the traditional hierarchical structure that somehow has been dysfunctional because of the acculturation stress (Landre et al. 1997; Le 2002).

Substance abuse. Substance abuse is another secret to be kept within the Asian American family, which tends to minimize the abuse and discreetly ask for help from trusted elders and relatives to talk to and reform the substance abuser. For Asian American youths, academic achievement is a protective factor for substance use, and peer substance use is a high risk factor for smoking, alcohol, and marijuana use (Thai et al. 2010). Drug abuse therapy is the last consideration and is turned to only after the family cannot care for the person misusing the substance or if he or she becomes violent or suicidal (Ja and Aoki 1993; Nemoto et al. 1999).

Alcohol consumption has a long history in Asian cultures. Confucian teachings and Taoism accept moderate use of alcohol at home and in ceremonies. In Japan and Korea, heavy or social alcohol consumption is considered the norm. Alcohol drinking and abuse are tolerated in Asian communities. Asian Americans seldom think of seeking help for problem drinking.

Gambling. Gambling is a problem for many Asian American families. Whether it is a gambling disorder, which causes big financial losses, or impulsive gambling, a gambling problem is considered shameful but is tolerated in the family. The family rarely mentions the problem or asks for help, probably because gambling involves mostly Asian American males and heads of the family. Gambling behavior and financial loss cause stress to the family members that can lead to a disruption of familial hierarchy, separation, or divorce (Petry et al. 2003).

Suicidality. Asian Americans are afraid to discuss the issues involving suicide. A national representative sample of 2,095 Asian Americans showed that the lifetime prevalence of suicidal ideation and attempts was 8.8% and 2.5%, respectively. The high-risk factors correlate to female gender, family conflicts, perceived discrimination, chronic physical conditions, and depressive and anxiety disorders (Chang et al. 2010). Among Asian American youths, the high-risk factors are low acculturation, parent-child conflicts, and conflict between parents (Groves et al. 2007). Other high risks for Asian American youths are high parental expectation, shame, intergenerational conflicts, perfectionism, and problem-solving deficiency (Barongan 2008).

Stereotypes. Interaction in therapy between the Asian American patient and the therapist who have different cultures and philosophies has the potential to stir up mutual stereotypes on both sides that manifest as transference and countertransference in therapy.

Transference. The traditional Asian American patient considers the therapist to be an expert, teacher, and guru who provides teaching and guidance to find solutions for the problems. The therapist is expected to mediate family discord, to judge, and to solve family conflicts. In the traditional Confucian hierarchical order in society (king, teacher, father), the therapist as a teacher is respected just below the king. Asian American youths and well-accultured Asian Americans may develop transference to consider the therapist as an elder in the family. Most Asian Americans expect to see the therapist maintain a warm, supportive, empathic, but authoritarian attitude to ensure their respect and trust (Juthani 1992; Marsella 1993). Asian American refugees and PTSD patients whose lives have been traumatized by war, imprisonment, or flight experiences may bring into therapy feelings of mistrust, suspicion, and hostility.

Their needs for therapy go beyond help for their psychiatric problems. In some cases, they may also look at the therapist as a benevolent teacher who will help them to get support and assistance to stabilize their living situation (Du and Lu 1997; Kinzie and Fleck 1987).

Countertransference. Facing the complicated and unfamiliar Asian cultural and health beliefs, the therapist may develop a defensive response of denial, whereby the therapist thinks that all patients are the same and ignores cultural factors in therapy. The therapist may also develop the opposite attitude, becoming overly curious about Asian cultures and spending substantial time exploring the culture instead of focusing on the patient's conflicts. American therapists who work with Southeast Asian refugees may develop feelings of guilt, pity, shame, or anger depending on their political point of view about the Vietnam War. A therapist may become "numbed" and not know how to respond while hearing extraordinarily horrible war and escape stories from refugees, or the therapist may become fascinated with the traumatic stories and explore for more when the patient is not ready to reveal much. Asian American therapists who share similar ethnic backgrounds with the patient may overly identify with the patient's struggles and conflicts and thus can stir up feelings of anger, guilt, or overprotection. In other cases, Asian American therapists may try to distance themselves from the patient to avoid overidentification, thus causing feelings of guilt and denial (Comas-Díaz and Jacobsen 1991). Asian American therapists may also have blind spots and may not ask particular questions because they think they know the answers or think that the subject is taboo.

Therapist authority. Therapist authority is very important in working with traditional Asian American patients. The "blank slate" approach in therapy may work for Asian American youths and well-acculturated Asian Americans but does not work well with traditional Asian Americans, who may feel confused, anxious, and awkward if treated as equal to the therapist. They will doubt the therapist's credentials and ability to understand and handle their problems (Marsella 1993). The therapist should maintain a warm, gentle, and supportive but authoritative attitude in therapy to build the therapeutic alliance, trust, and adherence. See Table 4–6 for a summary of tips for psychotherapy.

Table 4–6. Ten tips for psychotherapy with Asian Americans

1. Patients will normally be quiet and make poor eye contact.
 2. The therapist should self-reveal his or her credentials.
 3. A calm, gentle, and supportive manner helps to build a therapeutic alliance.
 4. A specific treatment plan should be outlined.
 5. The individual should be treated as a part of a family and community system.
 6. Problem-solving approaches may be helpful.
 7. Directive or cognitive-behavioral techniques can be used later in therapy.
 8. Use Asian metaphors.
 9. Group therapy may be helpful in patients with posttraumatic stress disorder.
 10. Consider the exploration of “taboo” subjects.
-

Language and the use of interpreters. The use of interpreters in evaluation and treatment is inevitable because Asian Americans speak many languages and dialects. Lee (1997a) recommended a “triangle model,” in which the clinician, patient, and interpreter are seated in an equilateral triangle (see Chapter 1, “Assessment of Culturally Diverse Individuals”). The following clinical case highlights the countertransference and inappropriateness of an interpreter.

Case 6

Mr. L. is a 21-year-old single Korean man who was admitted to the hospital for a suicide attempt after he overdosed with over-the-counter sleeping pills. A Korean interpreter was called to help in the evaluation. The assessment showed that the patient was the oldest son in the family and felt extremely guilty and stressed at home because his family disapproved of his homosexuality. His family had pressured him to marry a girl in Korea “to cure the problems.” After interpreting the reason for the stress and the patient’s suicide attempt, the interpreter began a lengthy conversation with the patient, then turned to the treatment team and said, “He will be fine. If you need to talk to his family, I am available for help.”

A Korean American medical student on the team told us that the interpreter was a pastor’s wife. She gave the patient a moral lecture on homosexuality and told him that if he would like to get out of the hospital, he should not tell the doctor that he was suicidal.

Overall Cultural Assessment (for Diagnosis and Care)

Working with Asian Americans and understanding their vastly diverse cultures and health beliefs is fascinating and challenging. Before the therapist can provide culturally appropriate treatment, he or she faces challenges to make an accurate evaluation, to overcome stigma, and to ensure compliance.

Misdiagnosis

Asian Americans seek treatment at the late stages of mental illness, when all other resources for help and alternative treatments have been exhausted. Evidence of traditional treatments using coining, pinching, or cupping that leave contusions, bruises, and petechial marks on the skin can be mistaken for signs of battering or abuse (Gellis and Feingold 1976; Yeatman et al. 1976). Similarly, moxibustion can leave small light burns on the skin that also may be mistaken for abuse. The therapist needs to investigate the use of traditional cures and herbal medicines that can cause severe psychotic symptoms to avoid misdiagnosis (Lin and Cheung 1999). Cultural concepts of distress that manifest differently from Western psychiatric disorders may be considered bizarre and psychotic, thus leading to misdiagnosis and an inappropriate treatment approach. Culturally appropriate beliefs such as feeling the presence of dead family members or seeing or hearing from the dead during the time of an anniversary of their deaths may be mistaken as psychosis (Lin and Lin 1980). The therapist should approach Asian American patients with an open mind and listen with empathy to their cultural health beliefs to avoid misunderstanding and misdiagnosis. The following is a case of *qi-gong* deviation syndrome.

Case 7

Ms. Z. is a 42-year-old married Asian American woman who was brought to the hospital by her family because she developed bizarre symptoms of uncontrollable and nonpurposed hand and arm gestures, episodes of fainting in the middle of her work, and sudden trancelike spells during conversation. According to her family, in the last 6 months, she had experienced increased moodiness, irritability with labile affect, crying spells, and poor memory and concentration. Ms. Z. reported that she felt uncomfortable because of pressure on the top of her head, dysphoric mood, and low energy. She indicated that she could not control her irritability or crying spells. She did not recall much about her episodes of fainting and trances but said that the uncontrollable gestures in her hands and arms happened soon after she started practicing *qi-gong*

breathing by herself 8 or 9 months ago. She said that she did not have these movements when she learned *qi-gong* in China. She had stopped practicing *qi-gong* for more than 5 years after she immigrated to the United States and resumed the practice of *qi-gong* as a method to calm her at work and relieve her anxiety about having slightly high cholesterol and high blood pressure.

Results of a physical examination, including neurological and cardiac examinations, were within normal limits except for mildly high blood pressure of 140/88. Ms. Z. had bizarre dancing-like gestures of both hand and arm. She had episodes of falling suddenly into a trance during interviews and occupational therapy groups and complained of loss of appetite, insomnia, palpitations, anxiety, weakness, and tremor in every limb. She was scared about what was happening to her. She reported hearing noises but no voices. She denied visual hallucinations or suicidal or homicidal thoughts. She was alert and oriented to name, time, and place.

Ms. Z.'s treatment in the hospital included lorazepam to calm her anxiety and help her sleep and acetaminophen for headache. Her family believed that she had "*qi-gong* deviation syndrome," in which her breathing exercise had led her *qi* to follow the wrong channels. The family asked permission to consult a *qi-gong* master who could evaluate Ms. Z.'s situation and provide *qi-gong* therapy to get her *qi* back to the right channels and places. She continued to take lorazepam, her behaviors were monitored, and she had therapy with a *qi-gong* master for 1 hour every day. Ms. Z. improved within a week. She was able to sleep better; her hand movements, auditory hallucinations of noises, episodes of trance, and fainting spells stopped. She was able to read newspapers, to watch television, and to focus on tasks in occupational therapy groups. Ms. Z. was discharged with referral information about community mental health clinics if necessary and with the recommendation that she practice *qi-gong* under the guidance of a master.

Overcoming Stigma

The stigma of having a mental illness is the most significant obstacle preventing Asian Americans from seeking help. Religious and cultural beliefs associate mental illness with guilt and shame that affect the patient and the whole family. Mental patients fear being rejected by siblings and relatives as well as the community, and they protect their family's reputation by denial and concealment (Gee and Mutsumi 1997). Overcoming stigma is difficult and challenging. Clinically, a biological explanation of mental illness helps to dispel part of the stigma of guilt and shame, particularly when the patient and family understand that mental illness is caused by neurotransmitter imbalances. Close cooperation among social services, health clinics, primary care provid-

ers, and psychiatric clinics is very important in providing psychoeducation about the benefits of early evaluation and treatment of mental illness in Asian American communities. Referral to support groups where the family can obtain help and information from others who have experienced similar struggles in coping with their mental illness is very helpful to lessen their feelings of being an outcast.

Ensuring Adherence With Medication and Appointments

Adherence to medication and treatment is another challenge of working with Asian Americans. Often, patients expect an immediate "cure." They have the tendency to reduce their medication dose when they encounter side effects or when their symptoms have improved (Kinzie et al. 1987; Lin and Cheung 1999; Lin and Shen 1991). They may drop out of therapy if they feel that the therapist does not understand them.

Kleinman (1980) suggested an explanatory model for understanding patients from different cultures and engaging them in treatment. Initially, the therapist should listen empathically and acknowledge the patient's and family's cultural health beliefs about the illness, then tactfully compare the similarities and differences between the patient's belief models and the therapist's clinical models. The first step in healing is to let patients tell their stories of mental illness according to their health beliefs. A treatment plan that includes a compromise between the differences in health beliefs will improve the patient's commitment to therapy. The physician should be a cultural broker, negotiating differences and addressing commonalities to create a compromise or a bridge between two cultures, working with both the patients and their families.

Most Asian American patients live with their families; therefore, family involvement in care plans is essential to support the patient and ensure his or her adherence to treatment. Family members can help bring the patient to doctor appointments, pick up medications at the pharmacy, give medications or remind the patient to take the medications, and monitor side effects and the patient's emotional and behavioral changes.

In the community, Asian Americans use mental health services more when they are able to participate in ethnic-specific programs in their own communities (Sue and McKinney 1975). They will stay in therapy longer and are less likely to drop out if they are matched with ethnically similar therapists or therapists who speak their primary language (Sue et al. 1991).

In Video 2–2, Dr. Ton concludes the interview with Mr. Tran.



Video Illustration 2–2: Treatment negotiation—Asian American (5:04)

Case 2 (*continued*)

Dr. Ton negotiates the treatment plan with Mr. Tran and at the same time provides reassurance and support with normalizing comments such as “I have worked with many Vietnamese patients, and they have suffered as you have, but there is hope.” The treatment plan described is multimodal, with counseling (learning skills for relaxation, controlling anger, and dealing with flashbacks), medication, mind exercises, and vocational and coping skills. Dr. Ton addresses Mr. Tran’s resistance to engaging in counseling, and at the end of the appointment, Mr. Tran agrees to come back.

Conclusion

Working with Asian Americans is a fascinating challenge that provides ample opportunities to learn about their cultures, health beliefs, and philosophies of life. An empathic, nonconfrontational approach that takes into consideration compromises of cultural differences in evaluation and therapy is crucial to understanding Asian American patients’ dynamics and therefore improving the potential to engage them in treatment. Therapists should pay more attention to vulnerable Asian American groups such as children, women, the elderly, and refugees. Because Asian Americans are sensitive to psychotropic medications, particular attention should be paid when prescribing medication (see Chapter 11). Knowledge of mental health needs, diagnostic issues, and methods of treatment of Asian American groups is essential to ensure appropriate, culturally competent approaches in therapy, treatment, prevention, and services.

References

- Akhtar S: Four culture-bound psychiatric syndromes in India. *Int J Soc Psychiatry* 34(1):70–74, 1988

- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000
- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Washington, DC, American Psychiatric Association, 2013
- Aoki BK: Gay and lesbian Asian Americans in psychotherapy, in *Working With Asian Americans: A Guide for Clinicians*. Edited by Lee E. New York, Guilford, 1997, pp 411–419
- Arameta EG Jr: Psychiatric care of Pilipino Americans, in *Culture, Ethnicity, and Mental Illness*. Edited by Gaw AC. Washington, DC, American Psychiatric Press, 1993, pp 377–412
- Aronson L: Traditional Cambodian health beliefs and practices: understanding Cambodian traditions will facilitate their care in a Western setting. *RI Med J* 70(2):73–78, 1987
- Barongan C: Suicide prevention in Asian American college students. Poster presented at the annual meeting of the Asian American Psychological Association, Boston, MA, August 2008
- Bernstein RL, Gaw AC: Koro: proposed classification for DSM-IV. *Am J Psychiatry* 147(12):1670–1674, 1990
- Boutakidis IP, Chao RK, Rodriguez JL: The role of adolescents' native language fluency on quality of communication and respect for parents in Chinese and Korean immigrant families. *Asian Am J Psychol* 2:128–139, 2011
- Caiyun W, Neuropsychology Department of Suzhou Medical College, et al: Spontaneous dynamic qigong (SDQ) (involuntary motion in qigong), and psychological medicine, presented at Joint Meeting of the American Psychiatric Association and the Chinese Medical Association: *Advances in Psychiatry: Chinese and American (Chinese Part)*. Beijing, China, 1988, pp 122–124
- Canda ER, Phaobtong T: Buddhism as a support system for Southeast Asian refugees. *Soc Work* 37(1):61–67, 1992
- Chang JKY, Fancher TL, Sue S, et al: Lifetime suicidal ideation and suicidal attempts in Asian Americans. *Asian Am J Psychol* 1:18–30, 2010
- Chen PN: A study of Chinese American elderly residing in a hotel room. *Soc Casework* 60(2):89–95, 1976
- Chung W: Asian American children, in *Working With Asian Americans: A Guide for Clinicians*. Edited by Lee E. New York, Guilford, 1997, pp 165–174
- Cima RJ: *Vietnam: A Country Study*. Washington, DC, Library of Congress, Federal Research Division, 1989
- Comas-Díaz L, Jacobsen FM: Ethnocultural transference and countertransference in the therapeutic dyad. *Am J Orthopsychiatry* 61(3):392–402, 1991

- Cook JM: Samoan patterns in seeking health services—Hawaii, 1979–81. *Hawaii Med J* 42(6):138–142, 1983
- Crohn J: Asian intermarriage: love versus tradition, in *Working With Asian Americans: A Guide for Clinicians*. Edited by Lee E. New York, Guilford, 1997, pp 428–438
- Du N, Lu FG: Assessment and treatment of posttraumatic stress disorder among Asian Americans, in *Working With Asian Americans: A Guide for Clinicians*. Edited by Lee E. New York, Guilford, 1997, pp 275–294
- Fairfax AE: 2010 Median Household & Individual Income—Asian Americans Top the List. Hampton, VA, The Census Channel. Available at: <http://censuschannel.net/cc/news/2010-median-household-individual-income-asian-americans-top-the-list-1330>. Accessed May 31, 2014.
- Gaw A: Psychiatric care of Chinese Americans, in *Culture, Ethnicity, and Mental Illness*. Edited by Gaw AC. Washington, DC, American Psychiatric Press, 1993, pp 245–280
- Gee KK, Mutsumi IM: Assessment and treatment of schizophrenia among Asian Americans, in *Working With Asian Americans: A Guide for Clinicians*. Edited by Lee E. New York, Guilford, 1997, pp 227–251
- Gellis SS, Feingold M: Pseudo-battering in Vietnamese children. *Am J Dis Child* 130:857–858, 1976
- Group for the Advancement of Psychiatry, Committee on Cultural Psychiatry: *Cultural Assessment in Clinical Psychiatry*. Washington, DC, American Psychiatric Publishing, 2002
- Groves SA, Stanley BH, Sher L: Ethnicity and the relationship between adolescent alcohol use and suicidal behavior. *Int J Adolesc Med Health* 19(1):19–25, 2007
- Hinton DE, Otto MW: Symptom presentation and symptom meaning among traumatized Cambodian refugees: relevance to a somatically focused cognitive-behavior therapy. *Cogn Behav Pract* 13(4):249–260, 2006
- Homma-True R: Asian American women, in *Working With Asian Americans: A Guide for Clinicians*. Edited by Lee E. New York, Guilford, 1997, pp 420–427
- Hsu J, Tseng WS: Intercultural psychotherapy. *Arch Gen Psychiatry* 27(5):700–705, 1972
- Huaihai S, Shanghai Mental Health Center, et al: A clinico-phenomenological study on mental disorder caused by breathing exercise, presented at Joint Meeting of the American Psychiatric Association and the Chinese Medical Association: *Advances in Psychiatry: Chinese and American (Chinese Part)*. Beijing, China, 1988, pp 1–2
- Huang DD, Charter RA: The origin and formulation of Chinese character: an introduction to Confucianism and its influence on Chinese behavior patterns. *Cult Divers Ment Health* 2(1):35–42, 1996

- Huang LN: Asian American adolescents, in *Working With Asian Americans: A Guide for Clinicians*. Edited by Lee E. New York, Guilford, 1997, pp 175–195
- Hughes CC, Littlewood R, Wintrob RM, et al: Culture-bound syndromes, in *Culture and Psychiatric Diagnosis: A DSM-IV Perspective*. Edited by Mezzich JE, Kleinman A, Fabrega H Jr, et al. Washington, DC, American Psychiatric Press, 1996, pp 289–323
- Ja DY, Aoki B: Substance abuse treatment: cultural barriers in the Asian-American community. *J Psychoactive Drugs* 25(1):61–71, 1993
- Juthani NV: Immigrant mental health: conflicts and concerns of Indian immigrants in the U.S.A. *Psychol Dev Soc J* 4(2):133–148, 1992
- Kao RSK, Lam ML: Asian American elderly, in *Working With Asian Americans: A Guide for Clinicians*. Edited by Lee E. New York, Guilford, 1997, pp 208–223
- Kim LIC: Psychiatric care of Korean Americans, in *Culture, Ethnicity, and Mental Illness*. Edited by Gaw AC. Washington, DC, American Psychiatric Press, 1993, pp 347–376
- Kim SC: Ericksonian hypnotic framework for Asian-Americans. *Am J Clin Hypn* 25(4):235–241, 1983
- Kinzie JD: Lessons from cross-cultural psychotherapy. *Am J Psychother* 32(4):510–520, 1978
- Kinzie JD, Fleck J: Psychotherapy with severely traumatized refugees. *Am J Psychother* 41(1):82–94, 1987
- Kinzie JD, Tran KA, Breckenridge A, et al: An Indochinese refugee psychiatric clinic: culturally accepted treatment approaches. *Am J Psychiatry* 137(11):1429–1432, 1980
- Kinzie JD, Sack WH, Angell RH, et al: The psychiatric effects of massive trauma on Cambodian children. *J Am Acad Child Psychiatry* 25(3):370–376, 1986
- Kinzie JD, Leung P, Boehnlein JK, et al: Antidepressant blood levels in Southeast Asians: clinical and cultural implications. *J Nerv Ment Dis* 175(8):480–485, 1987
- Kinzie JD, Sack W, Angell R, et al: A three-year follow-up of Cambodian young people traumatized as children. *J Am Acad Child Adolesc Psychiatry* 28(4):501–504, 1989
- Kleinman A: *Patients and Healers in the Context of Culture: An Exploration of the Borderland Between Anthropology, Medicine, and Psychiatry*. Berkeley, University of California Press, 1980
- Kleinman A: *Social Origins of Distress and Disease: Depression, Neurasthenia, and Pain in Modern China*. New Haven, CT, Yale University Press, 1986

- Landre R, Miller M, Porter D: Asian gangs, in *Gangs: A Handbook for Community Awareness*. Edited by Landre R, Miller M, Porter D. New York, Facts on File, 1997, pp 82–85
- Le T: Delinquency among Asian/Pacific Islanders: review of literature and research. *The Justice Professional* 15(1):57–70, 2002
- Lee E: Asian American families: an overview, in *Ethnicity and Family Therapy*, 2nd Edition. Edited by McGoldrick M, Giordano J, Pearce JK. New York, Guilford, 1996, pp 227–248
- Lee E: Cross-cultural communication: therapeutic use of interpreters, in *Working With Asian Americans: A Guide for Clinicians*. Edited by Lee E. New York, Guilford, 1997a, pp 477–489
- Lee E: Overview: the assessment and treatment of Asian American families, in *Working With Asian Americans: A Guide for Clinicians*. Edited by Lee E. New York, Guilford, 1997b, pp 3–36
- Lee SM: Asian Americans: diverse and growing. *Popul Bull* 53(2):1–40, 1998
- Lin EHB, Carter WB, Kleinman AM: An exploration of somatization among Asian refugees and immigrants in primary care. *Am J Public Health* 75(9):1080–1084, 1985
- Lin KM: Hwa-Byung: a Korean culture-bound syndrome? *Am J Psychiatry* 140(1):105–107, 1983
- Lin KM, Cheung F: Mental health issues for Asian Americans. *Psychiatr Serv* 50(6):774–780, 1999
- Lin KM, Finder E: Neuroleptic dosage for Asians. *Am J Psychiatry* 140(4):490–491, 1983
- Lin KM, Shen WW: Pharmacotherapy for Southeast Asian psychiatric patients. *J Nerv Ment Dis* 179(6):346–350, 1991
- Lin KM, Poland RE, Nuccio I, et al: A longitudinal assessment of haloperidol doses and serum concentrations in Asian and Caucasian schizophrenic patients. *Am J Psychiatry* 146(10):1307–1311, 1989
- Lin KM, Lau JK, Yamamoto J, et al: Hwa-byung: a community study of Korean Americans. *J Nerv Ment Dis* 180(6):386–391, 1992
- Lin KM, Poland RE, Nakasaki G (eds): *Psychopharmacology and Psychobiology of Ethnicity*. Washington, DC, American Psychiatric Press, 1993
- Lin KM, Cheung F, Smith M, et al: The use of psychotropic medications in working with Asian patients, in *Working With Asian Americans: A Guide for Clinicians*. Edited by Lee E. New York, Guilford, 1997, pp 388–399
- Lin TY: Neurasthenia revisited: its place in modern psychiatry. *Psychiatr Ann* 22(4):173–175, 177–187, 1992

- Lin TY, Lin MC: Love, denial, and rejection: responses of Chinese families to mental illness, in *Normal and Abnormal Behavior in Chinese Culture*. Edited by Kleinman A, Lin TY. Boston, MA, D. Riedel, 1980, pp 387–401
- Lu FG, Lim RF, Mezzich JE: Issues in the assessment and diagnosis of culturally diverse individuals, in *American Psychiatric Press Review of Psychiatry*, Vol 14. Edited by Oldham JM, Riba MB. Washington, DC, American Psychiatric Press, 1995, pp 477–510
- Marsella AJ: Counseling and psychotherapy with Japanese Americans: cross-cultural considerations. *Am J Orthopsychiatry* 63(2):200–208, 1993
- Masaki B, Wong L: Domestic violence in the Asian community, in *Working With Asian Americans: A Guide for Clinicians*. Edited by Lee E. New York, Guilford, 1997, pp i–xv
- Mollica RF, Lavelle J: Southeast Asian refugees, in *Clinical Guidelines in Cross-Cultural Mental Health*. Edited by Comas-Díaz L, Griffith EEH. New York, Wiley, 1988, pp 262–304
- Moore LJ, Boehnlein JK: Treating psychiatric disorders among Mien refugees from highland Laos. *Soc Sci Med* 32(9):1029–1036, 1991
- Nagata DK: Transgenerational impact of the Japanese-American internment: clinical issues in working with children of former internees. *Psychotherapy: Theory, Research, Practice, Training* 28(1):121–128, 1991
- Nakajima GA, Chan YH, Lee K: Mental health issues for gay and lesbian Asian Americans, in *Textbook of Homosexuality and Mental Health*. Edited by Cabaj RP, Stein TS. Washington, DC, American Psychiatric Press, 1996, pp 563–581
- Nemoto T, Aoki B, Huang K, et al: Drug use behaviors among Asian drug users in San Francisco. *Addict Behav* 24(6):823–838, 1999
- Ng BY: Qigong-induced mental disorders: a review. *Aust N Z J Psychiatry* 33(2):197–206, 1999
- Nguyen SD: Psychiatric and psychosomatic problems among Southeast Asian refugees. *Psychiatr J Univ Ott* 7(3):163–172, 1982
- O'Brien DJ, Fugita S: *The Japanese American Experience*. Bloomington, Indiana University Press, 1991
- Otto MW, Hinton DE: Modifying exposure-based CBT for Cambodian refugees with posttraumatic stress disorder. *Cogn Behav Pract* 13(4):261–270, 2006
- Petry NM, Armentano C, Kuoch T, et al: Gambling participation and problems among South East Asian refugees to the United States. *Psychiatr Serv* 54(8):1142–1148, 2003
- Prathikanti S: East Indian American families, in *Working With Asian Americans: A Guide for Clinicians*. Edited by Lee E. New York, Guilford, 1997, pp 79–100

- ProximityOne: America's Asian Population Demographic Patterns and Trends, 2014. Available at: http://proximityone.com/cen2010_asian.htm. Accessed May 4, 2014.
- Reid D: The Complete Book of Chinese Health and Healing. New York, Barnes & Noble, 1994
- Reid J, Silove D, Tarn R: The development of the New South Wales Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS): the first year. *Aust N Z J Psychiatry* 24(4):486–495, 1990
- Ross RR: Cambodia: A Country Study, 3rd Edition. Washington, DC, Library of Congress, Federal Research Division, 1990
- Rozee PD, Van Boemel G: The psychological effects of war trauma and abuse on older Cambodian refugee women. *Women Ther* 8(4):23–50, 1990
- Russell JG: Anxiety disorders in Japan: a review of the Japanese literature on shinkeishitsu and taijinkyofusho. *Cult Med Psychiatry* 13(4):391–403, 1989
- Ruzek NA, Nguyen DQ, Herzog DC: Acculturation, enculturation, psychological distress and help-seeking preferences among Asian American college students. *Asian Am J Psychol* 2:181–196, 2011
- Sack WH, Clarke GN, Seeley J: Multiple forms of stress in Cambodian adolescent refugees. *Child Dev* 67(1):107–116, 1996
- Savada AM: Laos: A Country Study, 3rd Edition. Washington, DC, Library of Congress, Federal Research Division, 1995
- Sue S, McKinney H: Asian Americans in the community mental health care system. *Am J Orthopsychiatry* 45:111–118, 1975
- Sue S, Fujino DC, Hu LT, et al: Community mental health services for ethnic minority groups: a test of the cultural responsiveness hypothesis. *J Consult Clin Psychol* 59(4):533–540, 1991
- Takaki RT: Strangers From a Different Shore: A History of Asian Americans, Updated and Revised Edition. Boston, MA, Little, Brown, 1998
- Tang NM: Psychoanalytic psychotherapy with Chinese Americans, in *Working With Asian Americans: A Guide for Clinicians*. Edited by Lee E. New York, Guilford, 1997, pp 323–341
- Thai ND, Connell CM, Tebes JK: Substance use among Asian American adolescents: influence of race, ethnicity, and acculturation in the context of key risk and protective factors. *Asian Am J Psychol* 1:261–274, 2010
- Tracey TJ, Leong FTL, Glidden C: Help-seeking and problem perception among Asian Americans. *J Couns Psychol* 33(3):331–336, 1986
- Tran TV, Manalo V, Nguyen VTD: Nonlinear relationship between length of residence and depression in a community-based sample of Vietnamese Americans. *Int J Soc Psychiatry* 53(1):85–94, 2007

- Tseng WS: Amok (indiscriminate mass homicide attacks), in *Handbook of Cultural Psychiatry*. San Diego, CA, Academic Press, 2001a, pp 230–233
- Tseng WS: Latah (startle-induced dissociative reaction), in *Handbook of Cultural Psychiatry*. San Diego, CA, Academic Press, 2001b, pp 245–250
- Tseng WS, Mo KM, Hsu J, et al: A sociocultural study of koro epidemics in Guangdong, China. *Am J Psychiatry* 145(12):1538–1543, 1988
- U.S. Census Bureau: Asian-Pacific American Heritage Month: May 2011. Profile America Facts for Features (press release). Washington, DC, U.S. Census Bureau, April 29, 2011
- U.S. Department of Commerce, Economics and Statistics Administration, Bureau of the Census: *We the Americans: Pacific Islanders*. Washington, DC, U.S. Department of Commerce, Economics and Statistics Administration, Bureau of the Census, 1993
- U.S. Department of Health and Human Services: *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2001
- Westermeyer J: On the epidemicity of Amok violence. *Arch Gen Psychiatry* 28(6):873–876, 1973
- Westermeyer J: Folk medicine in Laos: a comparison between two ethnic groups. *Soc Sci Med* 27(8):769–778, 1988
- Westermeyer J, Vang TF, Neider J: Refugees who do and do not seek psychiatric care: an analysis of premigratory and postmigratory characteristics. *J Nerv Ment Dis* 171(2):86–91, 1983
- Wong L, Mock MR: Asian American young adults, in *Working With Asian Americans: A Guide for Clinicians*. Edited by Lee E. New York, Guilford, 1997, pp 196–207
- Yamamoto J: Psychiatric diagnosis and neurasthenia. *Psychiatr Ann* 22(4):171–172, 1992
- Yeatman GW, Shaw C, Barlow MJ, et al: Pseudobattering in Vietnamese children. *Pediatrics* 58(4):616–618, 1976
- Ying YW, Miller LS: Help-seeking behavior and attitude of Chinese Americans regarding psychological problems. *Am J Community Psychol* 20(4):549–556, 1992

Suggested Readings

- Gaw AC (ed): *Culture, Ethnicity, and Mental Illness*. Washington, DC, American Psychiatric Press, 1993

- Gaw AC: Concise Guide to Cross Cultural Psychiatry. Washington, DC, American Psychiatric Publishing, 2001
- Gibbs JT, Huang L: Children of Color: Psychological Interventions With Culturally Diverse Youth. San Francisco, CA, Jossey-Bass, 1998
- Group for the Advancement of Psychiatry, Committee on Cultural Psychiatry: Cultural Assessment in Clinical Psychiatry. Washington, DC, American Psychiatric Publishing, 2002
- Herrera JM, Lawson WB, Sramek JJ: Cross Cultural Psychiatry. Chichester, UK, Wiley, 1999
- Holtzman WH, Bornemann TH: Mental Health of Immigrants and Refugees. Austin, TX, Hogg Foundation for Mental Health, 1990
- Kleinman A: Rethinking Psychiatry: From Cultural Category to Personal Experience. New York, Free Press, 1988
- Kleinman A, Lin TY: Normal and Abnormal Behavior in Chinese Culture. Boston, MA, D. Reidel, 1981
- Kleinman A, Kunstadter P, Alexander ER, et al: Culture and Healing in Asian Societies: Anthropological, Psychiatric and Public Health Studies. Boston, MA, GK Hall, 1978
- Lee E: Working With Asian Americans: A Guide for Clinicians. New York, Guilford, 1997
- Lin KM, Poland RE, Nakasaki G: Psychopharmacology and Psychobiology of Ethnicity. Washington, DC, American Psychiatric Press, 1993
- Locke DC: Increasing Multicultural Understanding. Thousand Oaks, CA, Sage, 1992
- Mezzich JE, Kleinman A, Fabrega H, et al: Culture and Psychiatric Diagnosis: A DSM-IV Perspective. Washington, DC, American Psychiatric Press, 1996
- Powell GJ: The Psychosocial Development of Minority Group Children. New York, Brunner/Mazel, 1983
- Simons RC, Hughes CC: The Culture-Bound Syndromes: Folk Illnesses of Psychiatric and Anthropological Interest. Boston, MA, D. Reidel, 1985
- Takaki RT: Strangers From a Different Shore: A History of Asian Americans, Updated and Revised Edition. Boston, MA, Little, Brown, 1998
- Tseng WS: Handbook of Cultural Psychiatry. San Diego, CA, Academic Press, 2001
- Tseng WS, Streltzer J (eds): Culture and Psychotherapy: A Guide to Clinical Practice. Washington, DC, American Psychiatric Publishing, 2001
- Tseng WS, Streltzer J (eds): Cultural Competence in Clinical Psychiatry. Washington, DC, American Psychiatric Publishing, 2004
- Westermeyer J: Psychiatric Care for Migrants: A Clinical Guide. Washington, DC, American Psychiatric Press, 1989

Issues in the Assessment and Treatment of Latino Patients

Amaro J. Laria, Ph.D.

Roberto Lewis-Fernández, M.D.

Hispanic or Latino groups include individuals from different countries who share substantial cultural and ethnic bonds through a common Spanish language and Latino/Hispanic ancestry. Although Latinos share common bonds, they are a heterogeneous group with richly diverse histories, customs, and cultural characteristics. An adequate understanding of issues pertinent to the psychiatric assessment and treatment of Latino patients in the United States requires a deep appreciation of the commonalities and the differences among individuals from these diverse groups. In the process of generalizing, we run the risk of oversimplifying complex cultural traits into gross stereotypes.

It should be noted that the terms *Latino* and *Hispanic* are used interchangeably throughout this chapter. Neither is a perfect choice because *Latino*

implies Latin descent and *Hispanic* gives priority to Spanish origins or language. These terms will be discussed in greater detail later in this chapter.

Appreciating the influence of culture on a particular individual's values and behavior requires walking the fine line between the pitfalls of *overculturalizing* (inaccurately attributing an observed individual characteristic to cultural factors) and *underculturalizing* (failing to recognize the influence of culture on an observed behavior or trait). For example, failing to appreciate the divergent views of gender relations that may be held by a young Argentinean immigrant woman who was raised in an affluent suburb of Buenos Aires compared with those of an older woman from rural El Salvador could result in simplistic stereotyping and overgeneralizing with little practical clinical value. On the other hand, dismissing existing commonalities between them because of their different social backgrounds also could cause important cultural information to be missed. Shared values toward family orientation, such as the need to preserve family cohesiveness at all costs, may represent a similar aspect of these women's experiences shaped by their common Latino cultural heritage.

Social Demographics and History of U.S. Migration Patterns

According to the U.S. Census Bureau, 53 million Hispanics resided in the United States in 2012, constituting 17% of the total U.S. population (U.S. Census Bureau 2013a). The Hispanic population increased by 15.2 million between 2000 and 2010, which represents a 43% increase. This accounted for more than half of the 27.3 million increase in the total U.S. population during that period. Projections estimate that the number of Hispanics will rise to 128.8 million, or about 31% of the U.S. population, by 2060 (U.S. Census Bureau 2013a). Ironically, although Spanish is not the official national language, the United States has the second largest Spanish-speaking population in the world (preceded only by Mexico and followed by Spain, Colombia, and Argentina). Latinos in the United States are a relatively young group, with a median age of 27.4 years, compared with 37.4 years for the overall population (U.S. Census Bureau 2013b; Pew Research Center 2012). Thirty-four percent of Hispanics are under 18 years of age, compared with 24% for the national population (U.S. Census Bureau 2012). In addition, it was estimated in 2012

that 64.3% of Hispanics living in the United States were U.S. born, contradicting the popular misconception of Hispanics as a population of immigrants (U.S. Census Bureau 2012). However, there is controversy as to the precise proportion of U.S.-born to foreign-born Latinos because of a potential marked undercount of Hispanic migrants in the U.S. Census Bureau data. One source estimates a more conservative figure of 40%–60% for each group (Alegría et al. 2004).

Persons of Mexican background are the largest Latino group in the United States, constituting 64.2% of the total Latino population (Pew Research Center 2014a). They are followed by Puerto Ricans (9.3%), Cubans (3.8%), Salvadorans (3.7%), Dominicans (3.1%), and Guatemalans (2.4%). As a group, Central Americans constitute 8.1% of the U.S. Latino population; South Americans account for 5.8%; and a category composed of Spaniards and others who self-label as “Spanish,” “Spanish American,” or “other Hispanic or Latino” represent 6.1% (U.S. Census Bureau 2012).

Eight states have more than 1 million Hispanics: California, Texas, New York, Florida, Illinois, Arizona, New Jersey, and Colorado (ranked in order of total Latino population). The states with the largest concentration of Latinos, in terms of percentage of total population, are New Mexico (46.7%), California and Texas (each 38.1%), and Arizona (30.1%) (Pew Research Center 2013a). In addition, Latinos are spreading to regions of the United States that have not previously been associated with large numbers of Latinos.

As a rule, Latinos have lower educational levels than the national average. Of the Latinos in the United States, 35% have not completed high school, compared with 8.7% of the total U.S. population, and only 14.5% have a college degree, compared with 33.6% of the total U.S. population (U.S. Census Bureau 2012) (Table 5–1). However, the various Latino groups differ from one another in this respect, with South Americans and Cubans generally having achieved a higher educational level than Puerto Ricans, Mexicans, Dominicans, and Central Americans (U.S. Census Bureau 2012).

Hispanics in the United States also have a significantly lower socioeconomic status than the U.S. average, as shown by various indices such as median family income (\$39,005 for Hispanics vs. \$57,009 for non-Hispanic whites and \$51,017 for the U.S. average), proportion of individuals below the poverty line (25.3% for Hispanics vs. 9.8% for non-Hispanic whites and 12.9% for the national average), and unemployment rates (10.8%, 7%, and

Table 5–1. Educational status, financial status, and employment status of non-Hispanic whites and Hispanics in the United States, 2012

Group	Educational level (%)				Economic level			
	Less than ninth grade	Less than high school	High school diploma	College degree	Median family income (\$)	Below poverty line (%)	Unem-ployed (%)	Uninsured (%)
White (non-Latino)	2.1	7.5	30.5	34.5	57,009	9.8	7.0	11.1
All Latinos	20.4	35.0	30.0	14.5	39,005	25.3	10.8	30.1
Mexicans	24.2	40.8	30.4	10.5	38,700	27.1	11.4	32.6
Puerto Ricans	9.4	24.0	32.6	17.5	36,000	29.1	13.0	15.7
Cubans	11.5	19.3	31.0	26.9	40,000	19.4	9.8	27.5
Central Americans	29.8	44.2	28.6	10.4	(no current data found)	24.7	8.0	39.0
South Americans	7.5	12.9	29.6	31.8	(no current data found)	11.7	7.0	25.6

Source. U.S. Census Bureau 2012, 2013c; Pew Research Center 2014a.

8.6%, respectively). The rate of Hispanics without health insurance (30.1%) is almost twice the national average (15.7%) (U.S. Census Bureau 2012). As in the case of education, marked intergroup differences exist.

Latinos have migrated to the United States for more than two centuries. Note, however, that many Hispanics were never immigrants because they inhabited regions of the country that were originally part of Spain and Mexico (i.e., Texas, California, New Mexico, Florida, Arizona, Colorado, Nevada) before the arrival of Anglo colonists, who came to these areas mainly during the nineteenth century (Parrillo 2005). This presents obvious ironies because many of their descendants may be inaccurately regarded in contemporary U.S. society as immigrants. The Spaniards were the first Europeans to settle in the Americas, arriving in 1492, one hundred fifteen years before the founding of Jamestown in 1607. Ponce de León, the former governor of Puerto Rico, was the first European to set foot in Florida, in 1513, and Saint Augustine, the first city established by European colonists in North America, was founded by the Spaniards in 1565. At the time the 13 colonies declared independence from Great Britain in 1776, Spain maintained control of most present-day U.S. territory west of the Mississippi River.

Subsequent to the early Spanish presence in the Americas, diverse historical and political events influenced the course of major migration trends from different Latin American countries. We describe some of these migratory patterns, as well as salient characteristics of Latino cultural groups, by classifying the groups into four geographic subcategories: Mexicans, Caribbean Islanders, Central Americans, and South Americans.

Mexicans

Mexico is the most populous Spanish-speaking country and the only one that shares a border with the United States. Therefore, it is not surprising that Mexicans constitute the largest Latino cultural group in the United States, estimated at 34 million in 2012 (Pew Research Center 2014a). Many Mexicans lived in parts of Mexico that later became U.S. territories (i.e., California, Texas, New Mexico, Arizona, Oklahoma, Nevada, and Colorado). They gradually became an ethnic and cultural minority after the United States formally occupied these territories following the Mexican-American War (1846–1848). Ironically, those whose families had lived in the region for generations

were suddenly regarded as foreign farmworkers in their own homeland. Subsequently, the Mexican Revolution (1910–1917) brought substantial social, economic, and political instability to Mexico, which triggered a massive migration to the United States (Parrillo 2005). The migratory flow increased after World War II and has persisted to the present day. In addition, many Mexican migrant workers come to the United States as temporary or seasonal rural laborers, returning to Mexico after limited periods of employment. Patterns of migration from Mexico have been influenced by economic conditions in the United States and in Mexico, as well as by changing political relationships between the two countries. For example, the United States has recruited Mexicans at times of need for cheap labor (e.g., during the construction of the railroad system in the 1880s) and has organized massive deportation efforts during periods of lower economic activity (e.g., the Great Depression) (Portes and Rumbaut 1996).

Although migration waves from Mexico have fluctuated according to socioeconomic factors both in Mexico and in the United States, there has been a steady increase of Mexican immigrants in recent years. The estimated unauthorized resident population from Mexico increased from about 2.0 million in 1990 to 4.8 million in January 2000 to 6.8 million in January 2011 (U.S. Department of Homeland Security, Office of Immigration Statistics 2012), when it was estimated that Mexicans represented 59% of the total unauthorized resident population in the United States. Yet despite the large number of undocumented Mexicans, the majority (66%) of those now living in the United States were born in this country (U.S. Census Bureau 2012), constituting the largest number of U.S.-born Latinos. The majority of Mexicans in the United States work as either service laborers or rural farmworkers.

Most of the nearly 34 million Mexicans in the United States remain a largely marginalized ethnic minority group. Factors leading to this situation include the harsh socioeconomic conditions in Mexico, the history of antagonism between the two countries, and the general tendency of U.S. dominant culture to discriminate against poor, dark-skinned or “colored” immigrants and resist their assimilation into U.S. society. Despite the antagonistic circumstances faced by many Mexican immigrants, their numbers continue to increase exponentially, and their migration patterns are diversifying across the United States.

Caribbean Islanders

There are three officially Spanish-speaking countries in the Caribbean: Puerto Rico, Cuba, and the Dominican Republic. Despite significant cultural characteristics shared by these *caribeños* resulting from their geographic proximity and common ethnic and historical roots, unique sociopolitical circumstances have resulted in divergent U.S. migration patterns. Because they represent the three largest groups of Latino immigrants in the United States after the Mexicans, we describe each group separately.

Puerto Ricans

The first sizable Puerto Rican communities in the United States formed in New York City around 1868, when many Puerto Ricans and Cubans migrated to organize revolutionary activities against Spanish domination (Rodriguez 1991). Puerto Ricans began to migrate in larger numbers after World War II in search of employment and better economic opportunities. Approximately 30% of Puerto Ricans living on the U.S. mainland reside in New York City, making it the largest Puerto Rican community in the United States. Other large concentrations of Puerto Ricans reside in Florida, New Jersey, Pennsylvania, Massachusetts, Connecticut, and Illinois (Pew Research Center 2013b).

An important fact that sets Puerto Ricans apart from all other Latino groups is the island's political status as a U.S. commonwealth, officially labeled an *estado libre asociado* ("associated free state"). By virtue of this political arrangement, extant since 1952, Puerto Rico is not an independent nation; despite some relatively autonomous elements of government, it still functions as a U.S. colony. Puerto Ricans have been U.S. citizens since 1917, making it easier for them to relocate to and work in the United States. Coupled with the relative geographic proximity of the island, this facilitates a continuous flow of Puerto Ricans back and forth from the island to the U.S. mainland, a process known as *circular migration*. Aided by routing and marketing decisions of the airline industry, many Puerto Ricans in the United States are able to maintain close ties with their culture of origin. Approximately 3.8 million Puerto Ricans live on the U.S. mainland, and another 3.8 million reside on the island. Of those living in the United States in 2010, approximately 70% were mainland born (Pew Research Center 2013b).

An interesting dilemma about Puerto Ricans living on the mainland is whether to regard them as immigrants, given their status as U.S. citizens. Despite their greater social and political ties with the United States, many Puerto Ricans still face substantial difficulty adapting to U.S. mainstream society, much like other Latino groups. In fact, they currently remain one of the most marginalized groups in the United States.

Similar to most Mexican immigrants, most Puerto Ricans on the mainland live in poverty and face discrimination and prejudice, sometimes resulting from historical and political hostility from U.S. mainstream society. However, there has been a marked increase in the number of Puerto Rican college students and professionals migrating from the island in more recent decades. Many Puerto Ricans living on the U.S. mainland contextualize their current marginalization in light of the prolonged colonial relationship between the two societies. The United States annexed Puerto Rico in 1898 after the Spanish-American War, imposing the English language and “Americanization” on the islanders and manipulating economic development to suit mainland priorities. Despite these efforts, the island has maintained its Hispanic heritage. Many Puerto Ricans, regardless of their political persuasion, view the United States with mistrust and are wary of the political and economic hegemony of their northern neighbor. However, Puerto Ricans vary widely in their political position toward relations with the United States, advocating political agendas that range from full independence to statehood. Although many resent their lack of autonomy from the United States, others see it as a strategic compromise.

Cubans

Cubans are the third largest Latino group in the United States, numbering approximately 2 million (Pew Research Center 2014a). They are also one of the most highly concentrated groups, with the vast majority (67%) living in southeast Florida, primarily in Miami-Dade County. Other states with large numbers of Cubans include New Jersey, New York, and California. Many Cuban revolutionaries who engaged in the struggle for independence from Spain migrated to the United States around 1868, establishing small communities in Florida and New York (Parrillo 2005). Skilled Cuban cigar makers were recruited by the growing U.S. cigar industry during the late nineteenth and early twentieth centuries, establishing communities in Tampa and Key West, Flor-

ida, in New York City, and in New Orleans, Louisiana. However, the largest exodus of Cubans to the United States began after the Cuban socialist revolution of 1959 and primarily after 1961, when leader Fidel Castro established a communist political and economic system in Cuba and broke relations with the United States.

Thus, unlike most other Latino immigrant groups, early Cuban arrivals in the United States were not poor socioeconomic immigrants but rather political refugees. These exiles tended to be wealthier, better educated, and characterized by their strong anti-Castro and anticommunist political stance, but subsequent migrations of *balseros* ("rafters") have included Cubans from all social strata (Portes and Rumbaut 1996). Another major exodus of Cubans took place during the 1980 Mariel boatlift, when a large group of predominantly working-class Cubans came to the United States. More recent Cuban immigrants appear to be motivated to migrate by socioeconomic as well as political factors.

An important difference between Cubans and the other two largest Latino groups in the United States, Mexicans and Puerto Ricans, is that Cubans, in general, maintain a more pro-U.S. political attitude. This should not be surprising. Many migrating Mexicans and Puerto Ricans view the history of relations between the United States and their countries of origin as a protracted resistance against northern economic and political encroachment. By contrast, many Cuban exiles regard the United States as their most strategic ally in their political opposition to Fidel Castro's, and more recently his brother Raul Castro's, Communist government.

Some prevailing misconceptions about Cuban exiles should be addressed. They are often stereotyped as an elite group among Latinos, with the erroneous implicit assumption that Cubans brought with them wealth that facilitated their adaptation to U.S. society and the attainment of high-status positions. Although some economic indices are better for Cubans compared with the Hispanic population at large, the economic position of Cubans is still substantially lower than that of the mainstream non-Hispanic white population. Rather than wealth, many Cuban immigrants brought job skills that facilitated their adaptation process, as a logical result of the urban, professional, and entrepreneurial sectors many of them represented in Cuba. Another factor is their establishment of an economic enclave, promoted through the solidarity and geographic concentration created by the group's political struggle. A second

common misconception about Cubans is that their pro-U.S. stance reflects an assimilationist attitude. In fact, as a rule, Cubans maintain a strong sense of ethnic identity and show low levels of cultural incorporation of U.S. mainstream values (Rogg and Cooney 1980). In addition, only 39.3% of Cubans living in the United States are U.S. born, compared with higher proportions of Mexicans and Puerto Ricans (U.S. Census Bureau 2012). Cubans also experience substantial prejudice and discrimination in this country and political tension with other Latinos and non-Latinos, who often stereotype them as political conservatives. However, the political views of most Cubans seem to have little to do with traditional U.S. political dichotomies of “liberal” versus “conservative” and more to do with what is most at stake for them, a “pro-Castro” versus an “anti-Castro” political stance.

Dominicans

Migrants from the Dominican Republic have entered the United States more recently, with the largest influx beginning in the 1970s. In the year 2012, there were nearly 1.6 million (Pew Research Center 2014a), concentrated mostly in New York City, where approximately 52% live, with other large communities in Massachusetts, New Jersey, and Florida (Pew Research Center 2014a). In the 1960s, following decades of unsupported authoritarian rule, including the Trujillo dictatorship from 1930 to 1961, the Dominican Republic experienced deteriorating economic conditions, such as a marked decline in agricultural production and a subsequent rise in unemployment (Portes and Rumbaut 1996). These factors triggered a massive exodus of migrants to Puerto Rico and the United States. Many Dominicans enter the United States as undocumented migrants via Puerto Rico. In that respect, they differ markedly from Puerto Ricans and the earlier waves of Cuban exiles who migrated legally. However, Dominicans are becoming more settled in the United States, and in 2012 approximately 47% of those living in the United States were U.S. born (Pew Research Center 2014a).

Like many Puerto Rican migrants, most Dominicans in the United States come from rural areas and low socioeconomic backgrounds and have a grade school education. This causes them to be the target of significant prejudice and discrimination from mainstream U.S. society. The fact that many Dominicans are dark skinned, given their mixed African, Amerindian, and European background, makes them additionally vulnerable to U.S. racist

attitudes (Portes and Rumbaut 1996). Another similarity to Puerto Ricans is the rise of a circular migratory pattern as a result of geographic proximity and the relative ease of air travel between the Dominican Republic and the East Coast of the United States. As a result, Dominicans engage in repeated back-and-forth cycles in an attempt to strengthen family, cultural, and economic ties between the two countries. Dominicans reside alongside Puerto Ricans in many communities, partly because of their cultural and socioeconomic commonalities (Parrillo 2005). Inter marriage between the two groups is increasing, although the degree of cultural intermixing varies by region, and each group typically has a strong sense of cultural identity.

Most Dominicans in the United States remain marginalized, despite their individual dedication and hard work, for reasons similar to those faced by Puerto Ricans, Mexicans, and other poor rural Latino migrants. Ironically, the low social status held by many Dominicans in the United States contrasts sharply with the positive image created by the success of the numerous Dominican professional baseball players who have become idols to thousands in the United States. It remains to be seen whether the dramatic concentration of the Dominican migration in a few ethnic enclaves (e.g., the Washington Heights area of New York City) will result over time in relative economic success similar to that of the Cuban exiles, despite the more limited number of migrants with professional-level skills.

Central Americans

Central America includes seven countries: Guatemala, Belize, El Salvador, Honduras, Nicaragua, Costa Rica, and Panama. Belize, a British colony until 1981, is the only non-Spanish-speaking Central American nation; therefore, Belizeans are not typically referred to as Latinos. Of the other countries, El Salvador, Guatemala, Honduras, and Nicaragua have sent the largest number of immigrants to the United States. An estimated 4.2 million Central Americans reside in the United States (U.S. Census Bureau 2012). Emigrants from these countries have left primarily for political and socioeconomic reasons. In fact, it is often difficult to discern factors related to poverty from those connected to political violence, given their close interdependence. Many Central American immigrants, especially Salvadorans but also Nicaraguans and Guatemalans, have experienced intensely traumatic experiences as victims of po-

litical violence, including imprisonment, torture, and widespread witnessing of killings. This exposure sets certain groups like the Salvadoran refugees apart from other Latino immigrants in terms of mental health, particularly because of the higher prevalence of posttraumatic reactions (Farias 1994).

Clinicians should make careful assessments of history of exposure to traumatic events and related reactions when working with Central Americans, especially those from El Salvador, Guatemala, and Nicaragua. Because of the harsh socioeconomic conditions in their countries of origin, Central American immigrants tend to be poor, from rural areas, and with low levels of education. An exception to this rule is the migration of some wealthier Nicaraguan refugees who escaped the Sandinista revolution of 1979, many of whom settled in the Miami, Florida, area. The racial ancestry of Central Americans also varies substantially across the countries in the region, with important consequences for the adaptation of particular groups to U.S. society. For example, a high proportion of the population of Panama and Honduras is of African descent, leading to the settling of many dark-skinned Panamanians and Hondurans in traditionally segregated black neighborhoods in the United States. *Mestizos* (primarily a mix of Spanish Caucasian and native indigenous groups) predominate among Salvadorans, Guatemalans, Nicaraguans, and Costa Ricans. In general, as with most other Latino groups, the social, economic, educational, and racial characteristics of Central Americans, in the context of a traditionally racist and segregationist host society, explain their general social and economic deprivation at the margins of U.S. society.

South Americans

South America is composed of 13 nations. With the exception of Brazil (official language Portuguese), French Guiana (official language French), Guyana (official language English), and Suriname (official language Dutch), the other nine countries—Venezuela, Colombia, Ecuador, Peru, Bolivia, Chile, Argentina, Paraguay, and Uruguay—are officially Spanish speaking. However, there are many indigenous languages and dialects that are widely spoken throughout the continent. In 2010, there were an estimated 3.1 million South American immigrants living in the United States (U.S. Census Bureau 2012). The largest groups of South American immigrants (listed according to group size) are Colombians, Ecuadoreans, Peruvians, Venezuelans, and Argentin-

eans (Pew Research Center 2014a). There has also been a substantial migration from Brazil in recent years. Although Brazilians share many cultural characteristics with other Latin Americans and are sometimes catalogued as “Latinos,” they are usually distinguished from Hispanic groups in the United States because of their Portuguese, as opposed to Spanish, heritage. (We expand our discussion of the usage of the terms *Latino* and *Hispanic* in a later section.)

Despite definite cultural differences across the various South American groups, there are certain commonalities that help explain their migration patterns to the United States. Many South American immigrants bring with them greater financial resources and higher levels of education than do Mexicans, Dominicans, and some Central Americans (Pew Research Center 2014a). This is due, in part, to their greater geographic distance from the United States, which makes it more difficult for individuals with very scarce resources to migrate. Although some South Americans arrive in the United States legally with tourist visas, others enter undocumented, primarily via Mexico. There are also important differences in the social and economic backgrounds of the various South American groups. In general, immigrants from Argentina, Chile, and Venezuela tend to come from more affluent backgrounds and to be more educated, more urban, and lighter skinned than most Ecuadoreans, Colombians, and Peruvians. It is important to note that these differences may be more reflective of the characteristics of the particular subgroups within those countries that are likely to migrate than of general cross-national differences. For example, the fact that some Argentinean and Chilean immigrants appear more educated than other Latinos in the United States may cause some people to overgeneralize and wrongly assume that these groups, at large, are more educated or sophisticated.

Another important difference among South Americans is their racial composition. Whereas some groups, such as Ecuadoreans, Colombians, Peruvians, Venezuelans, and Bolivians, have a large *mestizo* racial representation, others, such as Argentineans and Chileans, have a substantially larger European ancestry. These differences determine to a large extent the level of prejudice and discrimination that members of these groups are likely to face in the United States, as well as help explain some of the prejudices held by some members of these Latino groups against other Latinos.

Applying the DSM-5 Outline for Cultural Formulation

In the following sections, we apply the DSM-5 Outline for Cultural Formulation (American Psychiatric Association 2013) and show how it can be used to diagnose and treat Latino patients. We also illustrate some concrete skills that clinicians can use to facilitate the assessment of Latino patients in case vignettes and make reference to the video scenes that were excerpted from an interview of a Latina woman. We also review the DSM-5 Cultural Formulation Interview (CFI) and how it can be helpful in assessing a patient of Latino background.

Cultural Identity of the Individual

Cultural, Ethnic, and Racial Identities

Assessing a patient's cultural and ethnic identity is a complex process. It is essential for clinicians to make this evaluation on the basis of information provided by the patient rather than the evaluator's unsubstantiated assumptions. The clinician should ask patients to describe the culture with which they identify. Patients' descriptions of their social and family practices as well as other values and behaviors can provide a wealth of data about their level of involvement with their culture of origin. Interesting dilemmas may arise when patients' subjective identifications do not converge with more objective cultural assessments of their values and behaviors. For example, a patient may describe her cultural identity as "Latina," despite no knowledge of Spanish, no participation in practices characteristic of Latino cultures, and clear endorsement of values typical of Anglo-American mainstream culture. Nonetheless, her self-representation as a Latina provides useful information about how she likes to be categorized, even if this is more indicative of a desire to belong to that culture than of the direct influence of Latino culture on her values and behaviors.

In another potential scenario, a teenage boy born in the United States to Latino immigrant parents may defensively respond to inquiries about cultural identity by saying, "I'm American," thus resisting any categorization as Latino. Yet this teenager may speak fluent Spanish at home, live in a primarily Latino neighborhood, and engage in numerous Latino cultural practices. Similar to the previous example, his response provides valuable information about his subjective self-representation and wish for mainstream group membership.

However, taking his response at face value, without further inquiry and attention to other data related to observable cultural practices, could result in missing information that might be useful in developing an effective intervention strategy. In addition, the two individuals may be at different points in their racial identity development, as described in Chapter 3, “Issues in the Assessment and Treatment of African American Patients.”

Cultures are not static entities, and most Latinos in the United States, by definition, live in a multicultural context that causes ongoing modifications in their cultural identity. Intermixing with other ethnocultural groups is common, and Latino individuals and communities vary greatly in the degree to which they are affected by surrounding cultural influences. For example, the emergence of a hybrid Latino–U.S. African American culture in some large urban centers, the development of a local *Nuyorican* identity as an adaptive response by Puerto Rican migrants to the idiosyncrasies of New York life, and the evolution of a *Chicano* cultural identity among Mexican immigrants in California, Texas, and other U.S. southwestern states are cases in point.

Another important aspect of identity among Latinos is their perceptions of racial identity. Latin America is one of the most richly diverse regions in the world with regard to racial intermixing. Therefore, most Latin American societies have developed complex categorizations along a racial continuum with subtle gradations of “Europeanness,” “Africanness,” and “Indianness” that have little in common with more dichotomous/dichromatic U.S. concepts on the basis of the legacy of the “one-drop rule.” This is not to suggest that Latin American societies are devoid of racism. However, the physical cues that distinguish “whites” from “blacks” in the United States lack the same significance in many Latin American countries. For example, an individual who is regarded as white or *mestizo* in a Caribbean country may be classified as black in the United States. Coming to terms with a dichotomous conception of race is one of the hardships associated with migration for many Latinos. As a result, they typically resist U.S. “white/black” classifications. In the 2010 U.S. Census, Hispanics described their race as follows: 53% chose “white,” 36.7% “some other race,” 6% mix of “two or more races,” 2% “black or African American,” 1% “American Indian or Alaska Native,” 0.4% “Asian,” and 0.1% “Native Hawaiian and other Pacific Islander” (U.S. Census Bureau 2011, 2014). In general, Latinos have a stronger sense of group affiliation according to their cultural or ethnic identity than to their racial identity; this can cause

difficulties adapting to the United States, where racial identity precedes all other social categorizations.

Preferred Terms

The term *Hispanic* refers to persons who share a common language (Spanish) and a common cultural and ethnic heritage associated with either Spain or Spanish colonization. *Latino*, on the other hand, is generally used in the United States to refer to individuals who trace their heritage to one of the Spanish-speaking Latin American countries. However, the term can also be used to refer to those whose language has Latin roots, including not just Spain but also Portugal, France, and Italy and their colonies. This vagueness makes the use of the term *Latino* somewhat inconsistent because it is not clear, for example, whether it excludes Spaniards but includes Brazilians on the basis of geography or vice versa, on the basis of language. A preference for *Latino* over *Hispanic* exists among some in the United States for two main reasons: 1) a sociopolitical position advocating use of a Spanish term popularized by the group members themselves and 2) a desire to dissociate the group from the former Spanish colonizers and acknowledge the essential contribution of non-European ethnic and cultural elements to the formation of Latin American peoples. Other terms have been proposed, such as *hispanos* (Spanish for *Hispanics*) and *americanos* (Spanish for *Americans*), as a statement that Latin Americans residing in Latin America are also Americans as residents of the American continent, as well as to reflect a sense of belonging to a particular U.S. Latino subpopulation. Despite the lack of consensus, *Latino* and *Hispanic* are still the most common terms used in the United States by both Anglo and Hispanic Americans. Ironically, the term *Latin America* was deliberately coined by the French (Napoleon) in the mid-nineteenth century in an attempt to naturalize the expansion of their economic interests in Latin America by highlighting the “common” “Latin” roots of the French with the Spanish- and Portuguese-speaking peoples who inhabited the region.

Cultural Factors in Development

Family structure. Latino cultures tend to be family oriented, in the sense that most cultural activities center on the family unit, a high value is placed on family cohesiveness and interdependence, and family goals often supersede individual ones. This tendency has been described as *familismo* or “familism” in

social science research (Sabogal et al. 1987). Although a stronger bond typically exists within the nuclear family, the extended family also tends to play a central role in many Latino family dynamics. The concept of extended family may also go beyond grandparents, uncles, aunts, cousins, and in-laws. In many Latino groups, there is a strong family bond of *compadrazgo*, which signifies the relationship between parents and godparents, or *compadres*. Grandparents, especially, tend to occupy a central role in many Latino families, often becoming closely involved in raising grandchildren. Grandparents are also typically valued and respected as sources of advice and “old wisdom.”

Family cohesiveness among Latino immigrants tends to be enhanced with the migration process: greater family interdependence is common because of the loss of the extended family network. Moreover, the cohesiveness and solidarity that are common among oppressed groups in a society may reinforce these tendencies even further. An interesting aspect of family cohesiveness and interdependence is that these dynamics can serve as both sources of support and causes of marked distress. This duality is relevant to the assessment of mental health problems in Latino patients because very frequently these problems are rooted in disruptions within the family system.

Case 1 (Video 5)

Mrs. Santiago is a 52-year-old twice-married Nicaraguan woman who was admitted to the hospital after an episode of crying hysterically, shouting, and thrashing around in her bed. She had been preparing to fly to Nicaragua to join her husband at his request. Her husband of 23 years had taken their savings and left her 3 weeks earlier for a 21-year-old woman and began living in the family's retirement home. The week before, her husband had asked her to come to Nicaragua to be with him, to take care of him, and live with him and his new girlfriend because “she took care of him the best.” His intention was to have both his wife and his mistress present in their home in Nicaragua. She bought herself an airplane ticket and made plans to join him before her episode, despite her 23-year-old daughter's advice to stay in the United States. The day of her scheduled flight to Nicaragua, she “lost it” and was rolling on the bed, banging her head against the wall, screaming and crying, and yelling at everyone to leave her alone. She did not recall all of the events leading to her hospitalization. Her daughter called 911, and she was taken by ambulance to the hospital, evaluated, and later released. She noted that prior to her attack, she was distracted and had racing thoughts, had lost 5 pounds as a result of a loss of appetite, and complained of feeling angry with her second husband. Mr. Santiago was described as

an alcoholic and a womanizer (*mujeriego*), both of which Mrs. Santiago had tolerated. He had both physically and verbally abused her, telling her that she was “fat, ugly,” and that he was “tired of her,” but she had not told anyone of these events because she was afraid of what people would say.

In Video 5–2, the interviewer maintains a clear focus on the family and community as a core aspect of Mrs. Santiago’s contextualized experience. It is quite evident that her presenting problem is intricately embedded in her social world, particularly family dynamics. Aware of the centrality of the family in the patient’s presenting problem, the interviewer returns repeatedly to the topic of family dynamics in an attempt to attain a culturally grounded deep understanding of the patient’s problem. In this particular case, this focus is easily justified because it was intricately embedded throughout the patient’s illness narrative. In a different case, if the patient does not raise the topic of family dynamics, it is reasonable for the clinician to introduce this topic on the basis of prior knowledge of its centrality in the health-related experiences of many Latinos. Some possible questions that may be used to introduce the topic are questions 3–5 from CFI supplementary module 3, “Social Network,” which are similar to the ones used in the video.



Video Illustration 5–2: Gender values and community (3:21)

Compare the questions used in the video to the questions from the CFI listed below (American Psychiatric Association 2013):

3. Which of your family members, friends, or other important people in your life know about your [PROBLEM]?
4. What ideas do your family and friends have about the nature of your [PROBLEM]? How do they understand your [PROBLEM]?
5. Are there people who do not know about your [PROBLEM]? Why do they not know about your [PROBLEM]?

A therapist assessing a Latino patient might ask questions such as “What do your family members think about your problem?” “How do they respond to your symptoms?” “What do different members of your family believe is the

cause of your symptoms?” “How does your problem affect your relations with your family?” “How does it limit your activities with your family?” In Video 5–2, Dr. Boehnlein also asks Mrs. Santiago about her religious background and support, to which she replies that she is Pentecostal.

Taking an individuocentric approach to psychiatric assessments with Latino patients may result in the clinician’s missing key information with significant diagnostic, etiological, and treatment relevance.

Developmental issues. Regardless of whether we accept a proportion of 64% (U.S. Census Bureau 2012) or 40%–60% (Alegría et al. 2004) for U.S.-born Latinos, because of the relative youth of Latinos in the United States (35% are 18 years or younger compared with the national average of 24%), a substantial portion of the U.S. Latino population completes most of its development in this country. This should lead clinicians to consider the developmental effect of growing up and living as Latino in U.S. society. The potential negative consequences of ethnic minority status for child development—such as low self-esteem, low motivation and aspirations, and higher vulnerability to antisocial and disruptive behaviors—have been clearly documented (Phinney and Kohatsu 1997). Clinicians must carefully consider the influence of psychosocial developmental processes on any observed psychopathology.

Dependency-related behaviors are commonly evaluated in psychiatric assessments to determine the presence of psychopathology or behavior problems associated with developmental factors. Cultural factors influence the level of interdependence considered appropriate or “normal” among members of a particular group. The U.S. values of independence and autonomy, deeply rooted in European American Protestant traditions, contrast sharply with Latino cultural values of collectivism and group orientation (Marin and Triandis 1985). What may be regarded as normal levels of interdependence among Latino patients may be inaccurately assessed as overdependence by Anglo-American clinicians. For example, it is quite common for many young Latino adults to live with their parents until they get married, or during college, while showing culturally appropriate levels of independence and autonomy. Such behaviors, if assessed through a U.S. mainstream cultural lens, may be misinterpreted as indicative of overdependent personality styles.

Behaviors that are adaptive in a given cultural context may become dysfunctional in a different setting. Expanding on the previous example, a young

Latino adult raised in the United States who is in the process of deciding whether to move away from home to attend college may experience distress in attempting to reconcile internalized U.S. mainstream values of independence and autonomy with strong feelings of loyalty to preserving family closeness. In this case, the clinician should accurately assess the problem as stemming from a cross-cultural conflict rather than from pathological overdependence. Treatment can then focus on validating both conflicting tendencies and helping the patient reach an acceptable and functional compromise rather than steering the patient toward resolving misattributed overdependency needs.

Latinos tend to value and respect the elderly, who traditionally are seen as knowledgeable and wise. This often contrasts sharply with the “senior citizen” image commonly portrayed in many industrialized societies, such as U.S. urban settings, where citizens who are out of the workforce are regarded as weak, vulnerable, and unable to care for themselves. A case in point is the negotiation of nursing home placement for the elderly. Although increasingly common in some Latin American countries, nursing home placements are generally considered a last resort for many Latinos and, when pursued, tend to generate guilt, shame, and family distress. A more common practice among Latinos is for family members to take responsibility for the care of the elderly. However, as a result of adaptation to more typical U.S. lifestyles, many Latinos feel increasingly pressured to institutionalize their sick, elderly relatives. Clinicians should approach such situations with sensitivity, being mindful that these decisions tend to generate much distress for many Latino patients because of conflicts with their cultural values. Moreover, clinicians should avoid imposing their own cultural values regarding these decisions on their patients.

Gender Roles and Gender Relations

Gender roles tend to be clearly delineated in Latino cultures. The differentiation of gender roles in the prototypical traditional Latino family includes a heterosexual couple in which the woman is primarily involved in the functions of child care and home care and the man has the role of primary breadwinner. The mother’s role as a daily caregiver and nurturer makes the family *matrifocal*, counterbalancing the *patrilineal* character of authority. Undoubtedly, many Latinos conform to these traditional gender roles to some degree. However, Latino gender relations have been the object of much stereotyping.

The usual caricature describes an all-submissive female and an oppressive and aggressive male or *macho*. These stereotypes ignore the difference between pathological extremes of submission and aggression, on the one hand, and the diversification of gender roles that may serve an adaptive function within particular sociocultural contexts, on the other. Highly hierarchical societies with traditionally agricultural economies, such as those from which many Latino migrants originate, have been associated with more differentiated gender roles than is expected in postindustrial urban power centers.

Two terms to describe prototypical gender values among Latinos that have been widely used in the U.S. social science literature are *machismo* and *marianismo*. *Machismo*, which refers to men's attitudes and behaviors associated with sexual dominance and aggressive behavior, has been promoted in the United States almost as the quintessential trait of Latino men. The fact that this Spanish term has entered contemporary English language usage may reinforce the implicit notion that male oppressiveness is a particular trait of Latinos. Clearly, male dominance and aggressive behavior toward women exist in Latino cultures, as well as in most cultures, including U.S. mainstream society. However, the original notion of the term *macho* includes more than its inarguably negative aspects. It involves other adaptive features of culturally determined masculinity in Latino societies, such as personal responsibility; strength and bravery in the face of adversity; and being a good husband, father, provider, and protector of the family's honor at all times (Morales 1996).

The term *marianismo* is often regarded as a sort of cultural complement to *machismo*. It refers to qualities of culturally determined femininity presumably modeled after the Virgin Mary, such as submissiveness to men, acceptance of domestic chores and family responsibilities, and taking on an unconditional nurturing and self-sacrificing role as mother and wife. The term *machismo* has been popularized in Latino and U.S. mainstream cultures, but *marianismo* has seldom been used except in the U.S. social science literature. As with its male counterpart, *marianismo* tends to describe prototypical features of traditional female gender roles in most hierarchical societies of Mediterranean and Catholic background.

Case 1 illustrates an extreme version of *machismo*. Although such an extreme case may be found among Latinos (just as among members of any cultural group), its generalizability to a large number of Latino cases is limited. Nonetheless, if considered cautiously to avoid reinforcing exaggerated negative

stereotypes among Latino men, this case can serve to illustrate (as a sort of caricature) certain gender-specific roles and behaviors, such as those associated with the terms *machismo* and *marianismo*. At one point during the interview, the clinician asks a leading question that assesses for the value of *marianismo*: “It seems over the years that despite your husband’s behavior...that you still felt at some level that you needed to take care of him...and I’m wondering if you’d tell me where that came from” (Video 5–3). This is a risky question to ask as the clinician tries to walk the fine line between tuning into important cultural values while avoiding the endorsement of negative cultural stereotypes that may bias his assessment of the patient. Clinicians are urged to hold prior cultural knowledge as a tentative blueprint to inform a culturally sensitive clinical assessment while exercising significant caution to avoid making biased clinical judgments of a patient’s behavior on the basis of this general cultural knowledge.

Video Illustration 5–3: Family structure (4:27)

Spirituality and Religion

Roman Catholicism has been the dominant religion of all Hispanic countries. In the United States, however, the number of Latino Catholics appears to be declining. In a 2013 survey, only 55% of Latinos reported a Catholic affiliation (Pew Research Center 2014b). Latinos also engage in a diversity of spiritual and religious traditions that reflects the heterogeneity of cultural and ethnic influences in Latin America. A comprehensive analysis of elements of Catholicism that have permeated the values and behaviors of Latino cultures goes beyond the scope of this chapter. Some often cited and largely stereotyped examples of such values include *marianismo* (described in the previous section) and the expectation that female virginity will be maintained before marriage. However, other more positive aspects of Catholicism, such as the strong value placed on humility and selflessness, tend to be underemphasized, especially when critically examined through the lens of Protestant-dominant societies.

Diverse Protestant and other Christian traditions have grown in importance in recent years throughout Latin America and among U.S. Latinos. Common church affiliations of many Latinos in the United States include

Pentecostal, Evangelical, Jehovah's Witness, and Seventh Day Adventist. About 22% of Latinos in the United States identify as Protestant, the largest affiliations being Pentecostals (29% of Latino Protestants) and Baptists (19% of Latino Protestants). Approximately 3% of Latinos identify as "other Christians," the largest group being Jehovah's Witnesses (2%). About 1% identify with "other faiths" (e.g., Judaism, Islam, Buddhism), and 18% do not identify with any religion (Pew Research Center 2014b). Judaism is also practiced by many Latinos, especially from countries that received a large influx of European Jewish immigrants, such as Argentina and Chile. In addition to the religious traditions brought from Latin America, many Latinos have adopted new religions while living in the United States, including Islam, Buddhism, and spiritual practices associated with nontraditional or alternative philosophies and movements.

Given the mix of Amerindian, African, and European ethnicities in Latin America, a variety of religious and spiritual practices reflecting the intermingling of these traditions have also evolved. One set of traditions derives from the syncretism of African and Catholic practices, with a lesser influx of Amerindian elements. These include *santería* and *palo mayombe* among Cubans (Cabrera 1992) and *brujería* and *gagá* among Dominicans (Rosenberg 1979). Among these, *santería* is the most widespread among Latinos in the United States. This religious practice is a syncretism of African, primarily Yoruban, traditions and Catholicism. It involves an elaborate pantheon of deities called *orichas* or *santos* (saints) who exert influence over all elements of life. Most frequently, *orichas* are called on to intervene in matters related to health, wealth, and social relationships, especially those of a romantic nature. The practice of *santería* has spread from Cuba to other Latin American areas, such as Puerto Rico and the Dominican Republic, as well as to major U.S. cities, where it includes converts from diverse Latino and non-Latino groups.

Another set of indigenous traditions is usually subsumed under the generic label *curanderismo* and is characterized by a variety of folk healing practices primarily of Amerindian origin (Harwood 1981). *Curanderos* (indigenous folk healers) of various sorts are commonly employed as part of their help-seeking regimen by many Latinos, especially those of Mexican, Central American, and South American origin. Another spiritual practice that is popular among some U.S. Latinos is *espiritismo* ("spiritism") (Harwood 1987). The roots of *espiritismo* can be traced to the combination of nineteenth-century European spiri-

tualistic movements with syncretic folk healing practices in Latin America. Some of the countries and areas that received a significant influence of spiritism are Argentina, Brazil, Cuba, Puerto Rico, and Venezuela.

These practices have been stigmatized as nonscientific and primitive both in Latino cultures and in the United States, resulting in reluctance among practitioners to openly discuss their beliefs and involvement, especially with those outside their cultural group. These topics will be generally avoided in encounters with clinicians and researchers, who are assumed not to be accepting of these traditions. Clinicians should be cautious not to let the unfamiliar or exotic appearance of these practices lead to their pathologization because they often provide supportive and healing functions for those who practice them. The actual prevalence of these practices among U.S. Latinos remains unknown, given inconsistent results from various surveys (Hohmann et al. 1990; U.S. Department of Health and Human Services 2001). Although they are used by some, one must avoid overgeneralizing about the prevalence of these practices among Latinos.

Cultural Identity and the Cultural Formulation Interview

The CFI in DSM-5 offers some questions to guide the clinician during a cultural assessment that are useful as examples for formulating culturally relevant questions. The CFI consists of a 16-question core module, with 12 supplementary modules and an informant version, each with its own questions, some quite detailed. There are as many as 34 questions for cultural identity, although some questions are repeated from the core CFI. There are four domains of assessment in the CFI: 1) Cultural Definition of the Problem (questions 1–3); 2) Cultural Perceptions of Cause, Context, and Support (questions 4–10); 3) Cultural Factors Affecting Self-Coping and Past Help Seeking (questions 11–13); and 4) Cultural Factors Affecting Current Help Seeking (questions 14–16). Questions 8, 9, and 10 of the core CFI (see Appendix 1, “DSM-5 Outline for Cultural Formulation, Cultural Formulation Interview, and Supplementary Modules,” p. 483) are valuable aids in exploring the cultural identity of patients, and supplementary module 6, “Cultural Identity,” provides a series of questions to allow the patient to elaborate on his or her cultural identity. A key area to explore in this module is “National, Ethnic, Racial Background,” which includes questions such as the following:

1. Where were you born?
4. In terms of your background, how do you usually describe yourself to people outside your community?
6. Do you experience any difficulties related to your background, such as discrimination, stereotyping, or being misunderstood?

Another key area is “Language,” which includes the following questions:

8. What languages do you speak fluently?
9. What languages did you speak growing up?

For immigrants, a migration history is important; if the patient is a refugee, the clinician may need to use supplementary module 11, “Immigrants and Refugees,” to obtain a more detailed migration history. Common questions on “Migration” in the “Cultural Identity” module include

14. When did you come to this country?
15. What made you decide to leave your country of origin?
16. How has your life changed since coming here?
18. What are your concerns for your own and your family’s future here?

Questions about “Spirituality, Religion, and Moral Traditions,” “Gender Identity,” and “Sexual Orientation Identity” are also included in the “Cultural Identity” module (American Psychiatric Association 2013). (See Appendix 1.)

Cultural Conceptualizations of Distress

General Health-Related Concepts and Practices

There is great heterogeneity in health-related concepts and practices among Latinos, both in Latin America and in the United States. Reasons for this include individual differences and cultural variations related to diversity in national and regional origin, urban or rural background, education, and socioeconomic status. In general, Latinos with greater access to wealth and education favor evidence-based biomedical practices over indigenous forms of care. However, spiritual notions of health and emotional well-being are also common among Latinos across diverse socioeconomic strata, considerably

broadening the appeal of indigenous healing practices that are based on spiritual traditions.

The role of spirituality is reflected in ideas about the supernatural causation of illness, the power of prayer, faith, and certain folk healing practices (e.g., special baths with spiritually endowed natural compounds). Most spiritual forms of therapy among Latinos, however, are seen as adjunctive rather than alternative treatments; as a rule, conventional medical interventions are neither thought of as contraindicated nor routinely discouraged. For example, a person may believe that his or her cancer is caused by negative spiritual influence and consequently may engage in fervent prayer yet at the same time carefully follow medically prescribed chemotherapy.

For mental health disorders, however, several factors complicate popular acceptance of psychiatric diagnoses and treatments among many Latinos. These include the absence of concrete confirmatory diagnostic tests, the stigma attached to psychiatric labels and medications, and the perception that mental health disorders are just exaggerated versions of common coping difficulties in the face of adverse circumstances. As such, help for a mental disorder may be sought within the family, community, or church. However, many Latinos from societies with long psychotherapy traditions, such as Argentina, may be more open to particular forms of psychiatric treatment, such as psychoanalysis. In addition, the mind-body-social split is less pronounced among many Latinos than in mainstream Anglo-American culture, leading to more unified understandings of physical, emotional, and social (biopsychosocial) etiologies, symptoms, and treatments.

In Case 1, the interviewer shows cultural sensitivity by allowing the patient to describe the problem in her own words with personally and culturally syncretic narratives (scene not shown). By contrast, standard psychiatric interviews are conducted in a more structured manner, emphasizing evaluation of diagnostic categories. One potential limitation of this more focused and selective assessment is that it may have the unintended effect of deterring material that may be essential to an effective cultural evaluation of the presenting problem, leading to inaccurate diagnosis and treatment prescription as well as poor patient engagement in care. In addition, the interviewer makes several attempts to elicit the patient's explanatory model of her illness by asking direct questions, such as "I'm wondering how you explained that to yourself?" and "Why do you think this happened?" (Video 5–1). Such apparently obvious

questions tend to be left out in routine practice. Eliciting the patient's views about illness causation does not mean that the clinician will necessarily end up sharing them. Doing so, however, communicates cultural sensitivity and allows the clinician to evaluate the level of congruence or divergence between the views of the clinician and those of the patient. Areas of convergence in illness causation may facilitate treatment, whereas areas of divergence may need to be negotiated and hopefully reconciled to implement an effective intervention.



Video Illustration 5–1: Cultural concepts of distress—*ataque de nervios* (3:06)

The CFI also offers some examples of additional questions to ask in supplementary module 1, “Explanatory Model” (American Psychiatric Association 2013). The questions help the clinician to understand if the patient is influenced by illness prototypes, including questions such as “3. Had you ever had anything like your [PROBLEM] before? Please tell me about that” and “4. Do you know anyone else, or heard of anyone else, with this [PROBLEM]? If so, please describe that person's [PROBLEM] and how it affected that person. Do you think this will happen to you too?” Several questions in this module are based on Kleinman's original eight questions assessing an explanatory model (Kleinman 1980). The patient is also asked about the course of the illness, such as what the person thinks will happen and what the person imagines is the worst that can happen. Questions on help seeking and treatment expectations close this module, including a question about what the person and the family view as the proper treatment.

Predominant Idioms of Distress and Local Illness Categories

Indigenous views about health and illness contribute to shaping pathological emotional and behavioral expressions among Latinos. The notion of *nervios* (nerves) is common to many Latino groups. This general idiom of distress is based on the cultural view that the nervous system, including the anatomical nerves, is “altered” in unspecified ways by the effect of stressful life events, resulting in diverse pathological states. The severity of the effect is mediated by the person's vulnerability, which is believed to have both bodily (e.g., inherited, temperamental) and social or interpersonal aspects. On the one hand, this tends to normalize the pathology as an appropriate reaction to adverse circumstances,

unless it exceeds popular norms for symptom expression (e.g., violent or suicidal outbursts). On the other hand, the view that *nervios* is connected to at least transient “alterations” of the nervous system opens the door to the possibility of biomedical evaluation and treatment. Much of the cultural work involved in the determination of whether a person actually has *nervios* has to do with assessment of the relative relationship of stressors and vulnerabilities, the extent to which the person should be held responsible for controlling the distress, and the perceived risk of chronic and severe psychopathology.

Acute exacerbations of *nervios* may be labeled *ataques de nervios* (attacks of nerves) by some Latino groups, notably those of Caribbean origin, and are supposed to arise from overwhelming suffering, especially if unexpected. Formerly labeled a *culture-bound syndrome* or locally identified symptom complex in DSM-IV (American Psychiatric Association 1994) and now known as a *cultural concept of distress*, *ataque de nervios* refers to dramatic episodes of loss of control, accompanied by distressing, fitlike expressions of emotionality and physical symptoms. According to DSM-5:

Ataque de nervios (“attack of nerves”) is a syndrome among individuals of Latino descent, characterized by symptoms of intense emotional upset, including acute anxiety, anger, or grief; screaming and shouting uncontrollably; attacks of crying; trembling; heat in the chest rising into the head; and becoming verbally and physically aggressive. Dissociative experiences (e.g., depersonalization, derealization, amnesia), seizure-like or fainting episodes, and suicidal gestures are prominent in some *ataques* but absent in others. A general feature of an *ataque de nervios* is a sense of being out of control. Attacks frequently occur as a direct result of a stressful event relating to the family, such as news of the death of a close relative, conflicts with a spouse or children, or witnessing an accident involving a family member. For a minority of individuals, no particular social event triggers their *ataques*; instead, their vulnerability to losing control comes from the accumulated experience of suffering. (American Psychiatric Association 2013, p. 833)

Ataques do not have a one-to-one relationship with psychiatric disorders. In community epidemiological studies in Puerto Rico, they were found to be significantly more likely in persons with major depression, dysthymia, panic disorder, posttraumatic stress disorder, or generalized anxiety disorder than in persons without these disorders (Guarnaccia et al. 1993). The presence of *ataques* therefore does not signal a specific psychiatric disorder but rather

seems to be associated with the experience of being overwhelmed, which cuts across many forms of psychopathology. The episodes are supposed to call forth the person's support network, but they may be ineffective in situations of very limited resources, overly frequent distress, or cultural change, when the implied message may be misunderstood or unattended. In the companion interview (see Case 1, Video 5–1), Mrs. Santiago reported an *ataque de nervios* as a result of overwhelming emotional distress after finding out that her husband had left with his new girlfriend. The *ataque* eventually led to her seeking help.

Another idiom of distress that is common across several Latino groups has been labeled *somatization*, a tendency to report medically unexplained physical symptoms in the context of emotional distress (Escobar 1987). There is an inherent assumption, deeply rooted in biomedical culture and widespread among clinicians, that the tendency to somatize represents a more primitive or less adaptive mode of symptomatic expression. The verbal expression of emotional distress (often referred to as *psychologization*) is assumed to be more adaptive, as well as implicitly associated with a higher level of sophistication. However, the greater adaptive value of psychologization over somatization has yet to be proven. In fact, the universality of somatization challenges these assumptions (Kirmayer and Young 1998; Kleinman 1980).

Moreover, the tendency to express distress via somatic idioms should not be construed as an inability to express or even label emotional states. It seems to derive instead from the less pronounced nature of the mind-body-social split, as mentioned earlier. A.J. Laria and A. Calvillo ("Echoes of Migration: Medically Unexplained Symptoms Among Latino Immigrant Patients Attending a U.S. Primary Care Clinic," unpublished manuscript, 2006) found that most of the Latino primary care patients they studied who reported medically unexplained physical symptoms expressed clear ideas about the relationship between social, psychological, and physiological events. Rather than lacking verbal-psychological expressions to channel their emotional distress, these patients expressed it through a combination of verbal-psychological *and* somatic idioms. In fact, the apparent integration of "somatic" and "mental" forms of emotion may derive less from Latino cultural peculiarities than from historical commitments of the culture of biomedicine, which splits mental, physical, and social problems into separate entities. Ironically, although the health-related views of many Latinos seem quite compatible with the current biopsychosocial paradigm of health, clinical interventions that adequately ad-

dress relationships among biological, psychological, and social factors are scarce. New applied models and interventions are needed that can effectively target these biopsychosocial relationships in an integrative fashion.

Another important idiom of distress common to several Latino groups is that of reporting distressing perceptual alterations as signs of psychopathology. These perceptual changes include visual, auditory, and tactile/haptic experiences, with both illusory and hallucinatory phenomenology. Typical examples include seeing a shadow or a glimpse (*celaje*); hearing one's name called when alone; other auditory experiences, such as noises or mumbling sounds; and feeling the presence of someone nearby when alone. These experiences are often attributed to spiritual influences that are becoming manifest and distressing because of the weakened physioemotional state induced by the person's suffering. Although such phenomena are sometimes described by psychotic persons, most of these reports occur in persons with other forms of psychopathology or as nonpathological experiences (Lewis-Fernández et al. 2009).

Lewis-Fernández et al. (2010) found that these experiences are more frequent among psychiatric outpatients with childhood traumatic experiences. In this population, these experiences are associated with major depression but are largely independent of the presence of posttraumatic stress disorder. These reports are very prevalent in primary care settings, where they are more common in Latino than in non-Latino respondents and are associated with more severe distress, including greater suicidality and psychosocial impairment (Olfson et al. 2002). The same association with suicidal ideation and mental health disability was found in a nationally representative sample of U.S. Hispanics (Lewis-Fernández et al. 2009). Although often resulting from emotional distress, these experiences can easily mislead clinicians to diagnose a psychotic disorder when none is present, with the attendant risks of neuroleptic medication and missed attention to more salient psychosocial interventions. Evidence also indicates that these experiences can occur in the absence of any associated psychopathology. Labeling such nonordinary perceptual experiences "normal dissociative experiences," Laria (1998) identified high levels of intensity and frequency among a group of Cuban *mediums espiritistas* (spiritist mediums) who did not show any psychopathology or emotional distress. These findings further support the role of cultural factors in shaping these perceptual experiences.

Many other idioms and local illness categories are present among Latinos. Some of these are described in DSM-5 in the “Glossary of Cultural Concepts of Distress” (American Psychiatric Association 2013). Notable among them is *susto* (literally, “fright”), a cultural explanation especially common among Central Americans, Mexicans, and some South Americans. *Susto* typically follows a frightening event, which may or may not be of traumatic proportion, and is characterized by a mix of depressive, anxiety, and somatic symptoms. In the original Amerindian perspective, following the belief that fright causes the soul to leave the body, treatment consists of calling back the soul through a series of ritualistic events and cleansing the person to restore bodily and spiritual balance. Other Latino cultural categories of illness include *cólera* (literally, “rage”), also known as *bilis* or *muina*, and *mal de ojo* (evil eye), which are described briefly in DSM-IV-TR (American Psychiatric Association 2000).

Clinicians should appreciate that these cultural concepts of distress are intricately embedded in the patient’s sociocultural world. A parallel integrative nosological approach, using both Western and culturally congruent concepts, should be used in evaluating and treating these conditions, paying attention simultaneously to biomedical, psychological, and cultural factors relevant to illness and treatment.

Cultural Factors in Help Seeking

Studies have shown that Latinos in the United States underuse mental health services relative to non-Latino whites and to their own mental health need (Kouyoumdjian et al. 2003; Santiago-Rivera et al. 2011; U.S. Department of Health and Human Services 2001; Vega et al. 2007). Several studies have shown that Latino underuse extends not only to lower rates of initial entry into mental health care compared with non-Latino whites but also to poorer treatment retention once care has been accessed (Interian et al. 2013; Kouyoumdjian et al. 2003; Lewis-Fernández et al., in press; Padgett et al. 1994; Santiago-Rivera et al. 2002).

Structural and cultural barriers to utilization of mental health services. Various factors may account for Latino underutilization of mental health services. Structural barriers, such as low rates of insurance or the lack of bilingual, bicultural providers in low-income and rural areas where many Latinos reside, clearly impede overall access to care for Latinos (López 2002; Miranda et al.

1996; Santiago-Rivera et al. 2011; Vega et al. 2007). Financial limitations and inflexible job demands affect the ability to arrange for transportation, child care, and time off work.

Several studies have emphasized the key role that cultural factors play in creating barriers to care (López 2002; Vega et al. 2007). The substantial social stigma of carrying a mental health diagnosis and seeking mental health treatment among Latinos discourages many from seeking appropriate services, even when these are available. Latinos defined as more “traditional”—as measured by nativity, immigration status, language fluency, and degree of acculturation—consistently show significantly lower utilization than those with greater connection to mainstream U.S. society, even after control for differences in sociodemographic and economic status, physical and mental health status, and type of insurance (López 2002; Miranda et al. 1976; Vega et al. 2007). The 2001 supplement to the Surgeon General’s report on mental health singled out Latino immigrants as being particularly underserved with regard to mental health services (U.S. Department of Health and Human Services 2001).

Cultural congruence. The importance of migration and acculturation status in underutilization underlines the key role that cultural congruence plays in the process of health care access and retention. *Cultural congruence* refers to the degree to which the characteristics of the health care system match the cultural expectations of treatment in the target community. These expectations extend to the language in which the clinical encounter occurs, the nature of the workup and interpretation of symptoms, the treatments offered, and the outcomes envisioned. In addition, other important factors are the attitude toward including social support networks, such as folk healers and other spiritual religious practitioners, in recovery and the ways in which the perceived stigma of mental illness is addressed (Cheung and Snowden 1990; Guarnaccia and Rodriguez 1996; Kleinman 1980; López et al. 2002). Investigators have repeatedly noted that Latinos are typically responding to culturally syntonetic norms regarding these issues (López 2002; Rogler 1996; Vega et al. 2007). Therefore, the clinician should be aware of the cultural norms of the patient and, when appropriate, enlist the aid of a cultural broker (a consultant with appropriate cultural knowledge whom the clinician can consult about the effect of cultural factors on assessment and treatment). The following case vi-

nette illustrates the role of cultural factors in shaping how patients experience and describe psychiatric symptoms as well as their help-seeking expectations.

Case 2

Mrs. D. is a 56-year-old woman from Puerto Rico who migrated to New York City at age 27. Her husband died of a heart attack 3 years ago. She has one daughter, age 32, who lives close by, and a son, age 29, living in Florida. Mrs. D. was referred to a mental health clinic by her primary care clinician because of multiple chronic somatic complaints, including chest pain, headaches, fatigue, and pain in her legs. Mrs. D. reported that her symptoms began shortly after her husband passed away. She also experiences frequent crying spells whenever she thinks of her husband.

Several follow-up medical examinations found no apparent organic basis for her symptoms, resulting in a diagnostic impression of psychogenic factors underlying her condition and a referral to mental health. The referral note indicated “mixed depression and anxiety with somatization—no organic basis for her physical complaints.” At the mental health clinic, Mrs. D. saw a psychiatrist for a psychopharmacological evaluation and a psychologist for psychotherapy. She received a diagnosis of chronic depressive disorder with subsyndromal anxiety and somatization. Her evaluators also concluded that she was having a “protracted pathological grief reaction,” supported by the fact that her symptoms exceeded the 1-year limit typically expected for a “normal” grief process. Her pathological grief reaction was assumed to be caused by a combination of her cognitive style and her neurochemical makeup. A selective serotonin reuptake inhibitor antidepressant was prescribed, and she was referred for individual cognitive-behavioral therapy (CBT) for depression.

Mrs. D. initially showed some resistance to mental health treatment, insisting that her physical symptoms were “real” and “not in my head.” Although she acknowledged feelings of depression and anxiety, she explained that these were to be expected, given her being in mourning after her husband’s death. Moreover, she associated these symptoms with feeling estranged from her children, yet she said she did not want to impose on their lives, claiming that they were too busy with their own families. She expressed strong doubts that antidepressant medication would help her with her physical symptoms (her original chief complaint) and argued that her thinking style had nothing to do with her feeling sad because she missed her husband, to whom she had been very close. When the mental health clinicians tried to explain to her that normal grief reactions typically last about 1 year, she responded, “Sometimes you can feel very sad and depressed about someone you loved for your whole life.” Mrs. D. showed minimal response to the combi-

nation of antidepressant medication and CBT, and shortly thereafter she dropped out of treatment.

This case illustrates several points in the process of negotiating between a psychiatric evaluation and a Latina patient's explanatory model of illness. First, the primary care clinician's referral to mental health exemplifies conventional medical practice, which reflects a mind-body-social split that distinguishes between physical and psychological symptoms and separates them into distinct specialty systems of care. Despite the prevailing biopsychosocial model of health, social-contextual factors tend to be underemphasized in practice, as illustrated in this case, in which the major social factors associated with Mrs. D.'s distress—her husband's death and her estrangement from her children—were underemphasized in the treatment regimen. Instead, treatment focused on the neurochemical and cognitive aspects of her condition. This approach clashed with Mrs. D.'s understanding and expectations about her condition, and she interpreted the fact that her physical symptoms provoked a referral to mental health as indicative that her symptoms were regarded as "mental" and therefore not physically "real."

Care was predicated on the cultural assumption that a normal grief process should not exceed 1 year. Following from this assumption, Mrs. D.'s symptoms could not be attributed solely to a normal grief reaction. This clinical formulation contrasted sharply with the patient's explanatory model, which allowed for a more flexible and lengthy mourning process. Although she acknowledged that her physical symptoms were originally triggered by the stressful effect of her husband's sudden death, she still insisted that physical factors were involved in her symptoms.

Therapeutic failure in this case may be attributed to the inability to reconcile conventional medical and psychiatric formulations with the patient's explanatory model of illness. A more culturally congruent and potentially effective way of designing an intervention for Mrs. D. could have involved an attempt to negotiate between the two models from a truly integrative perspective. Working from a sociopsychosomatic model, the primary care clinician could have collaborated closely with the mental health clinicians as an integrative team working jointly to treat Mrs. D.'s symptoms. Moreover, accepting the cultural limitations of our biomedical assumptions could have allowed clinicians the flexibility to consider Mrs. D.'s symptoms as part of a culturally

shaped normative grief process. Such recognition could have led to a greater emphasis on the need to incorporate factors related to her grief process into her treatment.

Greater attention to the importance of social factors in her condition could have resulted in prioritizing the theme of her estrangement from her children in the treatment. Greater flexibility on the part of the clinicians to consider her explanatory model of illness also would have conveyed a sense of sociocultural validation. This might have facilitated Mrs. D.'s openness to trying other tools, such as antidepressants and culturally modified CBT, which were initially outside of her explanatory model. Thus, using culturally congruent integrated biopsychosocial treatment could have represented a satisfactory compromise between the explanatory models of patient and clinicians, leading to a greater likelihood of treatment adherence and effectiveness.

Psychosocial Stressors and Cultural Features of Vulnerability and Resilience

Social Context

In general, Latinos living in the United States are poorer, have darker skin, and are less educated, more lacking in marketable job skills, and less socially esteemed than white, Anglo members of the U.S. mainstream. Often, Latinos are the victims of substantial prejudice, discrimination, social neglect, and other forms of institutionalized violence. It is essential to recognize that the consequences of these social ills do not constitute cultural characteristics of Latino groups but rather cultural characteristics of U.S. society as a whole. Misrepresenting the negative consequences of social violence as individual or group psychopathology can serve to obscure the roots of these social problems and "blame the victims." To be treated effectively, socially rooted psychopathologies require interventions that recognize and address the social nature of these conditions, such as racism, classism, and stereotyping.

Higher rates of mood and anxiety disorders, substance abuse, and overall psychiatric disorders are reported among U.S.-born Mexican Americans compared with immigrants born in Mexico (Alegría et al. 2007; Escobar et al. 2000; Kessler et al. 1994; Vega et al. 2009). Moreover, the rates for recent migrants are similar to those obtained in Mexico City, and the rates for U.S.-born Mexican Americans are virtually identical to those of the U.S. main-

stream population as assessed in the National Comorbidity Survey (Kessler et al. 1994), anchoring the prevalence rates in national estimates at both ends of the migration continuum (Alegría et al. 2007; Vega et al. 1999, 2009). In addition, for Mexican migrants, a longer length of stay in the United States is associated with increased psychopathology (Vega et al. 1999, 2009). Mixed results were found in different comparative studies of lifetime depression among Puerto Ricans in New York City compared with those living in Puerto Rico (Canino et al. 1987; Moscicki et al. 1987; Vera et al. 1991), which suggests potential differences among Latino subgroups (Lewis-Fernández et al. 2005). The rates of substance-related disorders are alarmingly higher for U.S.-born Mexican Americans compared with Mexican immigrants—seven times higher for women and three times higher for men (Vega et al. 2009). Factors associated with living in, and especially growing up in, the United States seem to have a detrimental effect on the general mental health of Latinos (Alegría et al. 2007; Hernandez and Charney 1998; Vega et al. 2009).

The apparent paradox of these findings is that declining mental health often coincides with increased access to financial programs and health care services. Social indices by themselves do not explain these findings, and it is likely that cultural differences in lifestyle factors, expectations of mainstream culture integration, social roles, and loss of cultural protective factors play important roles.

Several times in the Case 1 interview, the interviewer asks the patient about her experience “back home,” prior to migrating to the United States (see Video 5–3). The clinician also suggests possible difficulties associated with Mrs. Santiago’s cultural adjustment to U.S. society. Standard diagnostic assessments and psychosocial functioning instruments frequently leave out questions about an immigrant’s experience prior to migration. Unfortunately, this lack of information on the patient’s sociocultural context may lead the evaluator to misattribute expressions of emotional distress and/or functional impairment associated with the process of cross-cultural adjustment solely to individual pathological factors. Attention to the migration process in the psychiatric assessment is crucial in light of the substantial body of evidence documenting the multiple challenges that Latino immigrants face during their cultural adaptation to U.S. society and how these can adversely affect their mental health status. The potential benefits of inquiring about the effect of immigration on mental health clearly outweigh any potential risk of asking leading questions

and being perceived as holding stereotypical assumptions a priori. In addition, this line of inquiry often indicates to immigrant patients that the clinician is culturally sensitive to their situation.

CFI supplementary module 3, “Social Network,” and module 4, “Psychosocial Stressors,” can help the clinician assess these important contributors to the patient’s clinical picture (see Appendix 1, pp. 497–499). The “Social Network” module includes the following questions on the “Composition of the Individual’s Social Network”:

1. Who are the most important people in your life at present?
2. Is there anyone in particular whom you trust and can talk with about your [PROBLEM]? Who? Anyone else?

In the section on “Social Network Understanding of Problem,” questions include the following:

3. Which of your family members, friends, or other important people in your life know about your [PROBLEM]?

The clinician will also want to know the “Social Network Response to Problem,” such as

6. What advice have family members and friends given you about your [PROBLEM]?
8. Can you tell me more about why you have chosen not to tell family or friends about the [PROBLEM]? How do you think they would respond if they knew about your [PROBLEM]?

The possibility that the social network helps attenuate the effect of mental health problems is explored in the supplementary module section “Social Network as a Stress/Buffer,” with questions such as “9. What have your family, friends, and other people in your life done to make your [PROBLEM] better or easier for you to deal with?” Finally, the last section, “Social Network in Treatment,” has questions such as “12. Have any family members or friends helped you get treatment for your [PROBLEM]?” (American Psychiatric Association 2013).

In CFI supplementary module 4, “Psychosocial Stressors,” the questions help to determine the stressors in a patient’s life, such as “You have told me about some things that make your [PROBLEM] worse. I would like to learn more about that.” “1. Are there things going on that have made your [PROBLEM] worse, for example, difficulties with family, work, money, or something else? Tell me more about that.” “3. How do you cope with these [STRESSORS]?” This module includes a specific question (question 7) on the effect of discrimination as a result of cultural identity (American Psychiatric Association 2013) (see Appendix 1, p. 499).

Stressors Related to Development and Legal Issues

Several studies have confirmed that Latino children and adolescents living in the United States have higher rates of depression and anxiety-related behavior problems than do mainstream non-Hispanic white children (Eaton et al. 2008; Glover et al. 1999; Potochnick and Perreira 2010; Roberts et al. 2006; Saluja et al. 2004). Similar to the case of adults, U.S.-born Latino children fare worse than immigrant children born in Latin America. Mexican American children, for example, report higher rates of depression, suicide, and drug use than do Mexican children (Escobar and Vega 2000; Harker 2001; Peña et al. 2008). An alarming finding is that although U.S. Latinos in general have a lower suicide rate than the U.S. mainstream population, U.S. Latino adolescents report higher rates of suicidal ideation and suicidal attempts than do either white or African American children (Canino and Roberts 2001; Eaton et al. 2008, 2012). Given that more than one-third of Latinos in the United States are younger than 18 and that most Latino youths are U.S. born, these findings suggest an extraordinary epidemic of mental health problems among Latino children and adolescents.

Another area of concern is the extremely high rates of law-related behavior and mental health problems among U.S. Latinos. Latino prison inmates outnumber non-Latino whites by three to one (3.7 to 2.2) (U.S. Bureau of Justice Statistics 2010). Furthermore, Latinos are four times more likely than non-Latino whites to be imprisoned at some point in their lives, and Latino youths have much higher delinquency rates (U.S. Bureau of Justice Statistics 2010; Vazsonyi and Flannery 1997). In addition, incarcerated individuals have higher rates of mental health problems than do community residents (Teplin 1994; Trestman et al. 2007; U.S. Bureau of Justice Statistics 2010).

Social Support: Protective Factors

Some characteristics of Latino cultures appear to function as protective factors against mental health problems. For example, one suggested explanation for the lower suicide rate among Latinos, as compared with non-Latino whites (Oquendo et al. 2001), is their high reliance on spirituality, which promotes a sense of hope and acceptance in the face of adversity. Another protective factor appears to be immigrant status. Immigrants may be protected through a sense of hardiness and hope in the future, especially when compared with the economic hardships they suffered “back home” (Suarez-Orozco and Suarez-Orozco 1995; Vega and Scribney 2011). Conversely, the healthier outcomes among Latino immigrants may have more to do with the mere absence of the increased vulnerability that U.S.-born Latinos experience because of their ethnic minority status in U.S. society and the differential treatment and detrimental effects that result from it.

Social orientation also appears to be a protective factor among Latinos. In light of the importance of social support in promoting mental health, the more sociocentric orientation of Latinos compared with a more individualistic U.S. mainstream culture may foster greater family and community support. An illustration of this in terms of the positive role of the extended family is the lower rates of foster home placement for Latino children and of nursing home referrals among Latino elderly, who tend to be cared for at home (Angel 1998; Santiago-Rivera et al. 2002; Vega and Scribney 2011).

The following case illustrates the influence of the psychosocial context of U.S. Latinos on an individual’s psychopathology and level of functioning.

Case 3

Miguel is an 11-year-old Mexican American boy who was referred for psychiatric evaluation by his school counselor because of his increasing distractibility in school and his inconsistent pattern of academic performance. Psychiatric assessment identified attention difficulties and yielded a diagnosis of attention-deficit/hyperactivity disorder (ADHD). A combination of psychopharmacological management and behavioral therapy for his inattentiveness and hyperactivity was prescribed. Miguel’s mother requested permission to leave work early once a week to take Miguel to his weekly psychotherapy appointment. Besides the financial stress that resulted from this, the parents also struggled to afford Miguel’s medications, which were not covered by their insurance. Miguel showed only minimal responsiveness after 6 months, at

which point his parents decided to discontinue his treatments. The clinicians working with Miguel argued that the parents did not allow the intervention sufficient time for him to show any significant progress and claimed that they had acted irresponsibly given that their son's condition required treatment.

A closer look at Miguel's psychosocial life shows a Mexican immigrant family struggling with substantial financial stress to provide for a family of nine. Both parents had to work; consequently, the children spent a large amount of time on their own. Miguel would typically be supervised by one of his older siblings. His 17-year-old brother, Pacho, had been hospitalized a month earlier after being shot and seriously wounded in a street gang fight. This incident was very upsetting for the entire family, especially for Miguel, who was very close to Pacho. In addition, there had been several other recent incidents of relatives and neighborhood acquaintances who had been involved in violent incidents, including some fatal cases. Furthermore, the family had received several threats from gang members involved in Pacho's shooting. Their home had been broken into on two occasions, resulting in loss of valuable personal belongings. Another of Miguel's siblings had been arrested on drug-related charges and was spending time in a correctional institution. The parents were very concerned about violence in their neighborhood and about their increasing loss of control over their children. However, they were unable to afford a move into a safer neighborhood because of their tenuous financial situation.

Cases of ADHD in the United States have risen to almost epidemic proportions in recent years, especially among children. Although there is support for a neurochemical basis of ADHD, difficulties in attention can also be associated with high levels of psychological stress. A closer examination of Miguel's psychosocial experience provides information relevant to assessing his level of functioning. Going beyond an exclusively biomedical etiology to conduct a more comprehensive assessment would confirm the value of contextualizing Miguel's attentional dysfunction within the elevated psychosocial stress that characterizes his life. Medication management and behavioral therapy focused on his attention problem could have been better integrated into a more psychosocially relevant treatment. This more integrated approach would have taken into account the psychosocial stressors that most likely played an important role in the etiology and maintenance of his condition, resulting in a more effective treatment.

Cultural Features of the Relationship Between the Individual and the Clinician

Expectations of Mental Health Practitioners

In general, Latinos tend to regard clinicians as experts and to expect authoritative opinions and advice. They also expect providers to show genuine caring and concern for their patients, which, for Latinos, is communicated overtly via personal warmth in direct personal interactions. The formal, personally detached, and neutral professional stance that is quite normative among many health care providers in the United States is often interpreted by Latino patients as indicative of a cold, impersonal, and therefore uncaring clinician. In addition, as ethnic minority group members, many Latino patients have experienced significant prejudice and discrimination in the United States, which may predispose some to initial distrust and guardedness, especially with Anglo-American clinicians. This should be understood as a generalized defensive reaction with some adaptive value, offering protection against real experiences of prejudice. In general, as increased contact yields evidence of the clinician's genuine concern, most Latinos will be able to establish a trusting therapeutic relationship regardless of differences in cultural, ethnic, or racial backgrounds. In contrast, empathic failures on the part of clinicians who behave in a rude, condescending, or excessively impersonal manner may confirm patients' negative expectations, leading to distrust and impeding a therapeutic alliance. Given the cultural value placed on politeness, many Latino patients may not express their disgust openly toward these clinicians, yet they may resist treatment recommendations, cancel appointments, or drop out of treatment. Clinicians may feel confused when they misinterpret a polite attitude as acceptance of their recommendations and prescribed treatments.

Styles of Communication

Verbal communication. As in every country or large geographic area sharing a common language, there is a wide range of national and regional accents and colloquial forms of Spanish that clearly distinguish Latinos from diverse countries and regions. Language is also an important way of communicating social class, educational level, and urban or rural origin. Often, there is a confounding of social and national differences, given the specific class, geographic, or educational characteristics of particular groups who migrate from

the various Latin American countries. For example, the verbal style of many Argentinean or Chilean immigrants may indicate more advantaged educational and class backgrounds compared with many Puerto Rican or Mexican migrants, who may be of working-class origin.

In addition, language can reflect the level of acculturation of a Latino individual. Most Latinos in the United States are bilingual to some degree but with different levels of proficiency in Spanish and English. A common mistake among clinicians is to assume that cross-cultural factors are not relevant in working with English-proficient Latino patients. Latinos who are predominantly English speaking may still have a strong affiliation with a Latin American or U.S. Latino culture.

Another mistake commonly made by clinicians is to assume that because a Latino individual speaks English with a particular accent, he or she is more fluent in Spanish, thus confusing a regional or subcultural accent (e.g., the typical *Nuyorican* or *Chicano* patterns of speech) with lack of English proficiency. Such individuals may be inappropriately referred to Spanish-speaking clinicians on the assumption that they will be able to communicate better in Spanish. Therefore, clinicians must be cautious in making assumptions that lead to cultural and linguistic matching; the best practice is always to ask patients directly about their preferences. A patient's preferred language can also be a way of making an important personal statement. For example, Latino individuals who are fluent in English yet prefer to communicate in Spanish with other Latinos are typically expressing their level of cultural pride and their comfort with adopting a Latino cultural identity in the United States.

Finally, the language used during the clinical interview may affect the level of psychopathology perceived by the clinician. Some evidence suggests that Spanish-dominant individuals may appear either more or less pathological during a psychiatric evaluation carried out in English. Some research supports the notion that the greater difficulty of communicating in an unfamiliar language may cause the patient to exert greater care in self-presentation and decrease spontaneous speech, thereby reducing the florid expression of psychopathology (Price and Cuellar 1981). By contrast, other studies suggest that the additional communication barrier caused by the use of English makes patients appear more pathological than they really are, particularly with regard to the evaluation of thought process, which is usually done through observa-

tion of language production (Marcos et al. 1973; Shrout et al. 2008). Higher rates of psychopathology were also found among bilingual (Spanish-English) individuals (Malgady and Costantino 1998). Clearly, language use and level of English fluency are important considerations in assessing psychopathology among Hispanics.

Latinos often use *dichos* ("sayings") or *refranes* ("proverbs") in their narratives. These play an important function, situating an individual's experience in the context of cultural wisdom acquired through generations. Careful attention to the use of *dichos* or *refranes* in the clinical setting may identify important elements of an individual's experience shaped by his or her cultural values. In Case 1 (Video 5–3), Mrs. Santiago uses a typical proverb in Spanish, *no saques los trapos afuera* (which translates literally as "Don't put the rags outside," similar to the English saying "Don't wash your dirty laundry in public"). The use of this proverb describes a culturally reinforced value that discourages disclosing sensitive personal information outside the close family circle. The patient uses this proverb to explain her previous tendency to tolerate her husband's infidelity, abuse, and drinking and the shift to a growing realization that she did not have to continue to put up with his behavior. This *refrán* illustrates her potential conflict and ambivalence about refusing to continue to tolerate his behavior and seeking outside help. The use of sayings and proverbs by Latino patients can be very telling because they may provide cultural information with direct relevance to clinical assessment and treatment. If unclear of the meaning, the clinician should seek clarification from Spanish-speaking colleagues or other adequate sources and bring the topic back to the next session for continued exploration. Besides enhancing understanding of the patient's history, this will convey cultural sensitivity by the clinician, facilitate rapport, and reinforce the continued use of culturally relevant expressions.

Nonverbal communication. Like all cultural groups, Latinos from various national origins have particular nonverbal styles of communication. Many Latinos show a preference for direct and personal interactions and place less emphasis on formality and social distance. This may emerge in a clinical situation as a more interactive style, personally revealing stories, and informal and humorous comments. Latinos' emphasis on politeness may be communicated through behaviors such as handshakes, as well as through social agreeability and more receptive attitudes. Some Latinos may interpret the mainstream Anglo-

American value of having an assertive personality, which is often communicated through an individualistic “critical consumer” stance, as rude and impolite. Similarly, some Anglo-Americans may misinterpret the overt politeness expressed by many Latinos as a lack of assertiveness, when actually it may be a highly valued sign of social competence in Latino culture. Anglo-American clinicians frequently misinterpret the level of agreement expressed by a Latino patient as signifying the patient’s acceptance of treatment recommendations and likelihood of adherence to them, only to be confused when the patient shows poor adherence in following their recommendations.

Social distance and physical touch are two potential areas of confusion and misinterpretation in clinical situations. Appropriate social distance among Latinos tends to be closer than the typical norm for Anglo-American culture, and physical touch is more common. Handshakes are expected during most introductions or greetings, and kissing is very common. The appropriateness of kissing is also subculture-specific and class-specific, as well as generational. For many Latinos, especially younger adults from urban areas, kissing on the cheek is typical when either greeting an acquaintance or being introduced to someone in a social situation. Hugging tends to be a sign of closer affection and is usually reserved for relatives and close friends. The following scenario encountered by the first author illustrates some of the ways in which confusion may arise in a clinical setting as a result of differences in non-verbal communication.

Case 4

The 6-year-old daughter of a recently migrated Argentinean couple was referred to an outpatient community mental health clinic for evaluation of a possible anxiety disorder. After several meetings, the girl naturally began to approach the therapist to greet him with a kiss on the cheek. Because treatment also involved family sessions, the father would always shake hands with the therapist on greeting him, and over time the mother’s greeting naturally evolved from a handshake to a kiss on the cheek. The clinician interpreted these behaviors as culturally appropriate, especially in the context of forming a close personal relationship. Having been raised in a Latino culture, yet also acculturated into professional norms typical of psychotherapy training in the United States, the therapist experienced a cross-cultural ethical dilemma. Greeting patients with a kiss would undoubtedly be interpreted by colleagues as a clear violation of professional boundaries. On the other hand, the pa-

tient's family would likely see refusing the socially appropriate greeting from the mother and daughter as a sign of coldness and rejection. Reaching a compromise was challenging, and there was significant disagreement, even among Latino therapists working at the clinic, about how to behave appropriately. After peer consultation, the therapist chose to continue to reciprocate the culturally determined behavior.

The solution to a given dilemma will depend on the particular circumstances of each case, as well as on the clinician's degree of comfort with adjusting his or her behavior in the service of the patient-clinician relationship. Obviously, Latino patients may also exhibit inappropriate behaviors. As with any other behavioral assessment, if unclear in the interpretation of a given situation, a clinician will need supplemental information, further inquiry and observation, and possibly consultation from cultural experts. In Case 4, a non-Latino clinician might not have felt the same level of comfort in reciprocating the patient's and mother's behaviors. However, the key issue was making an accurate assessment of the behavior in terms of the adequate cultural frame of reference—in this case, kissing as an appropriate sign of social appreciation. The non-Latino clinician could have replaced the kiss with a culturally equivalent sign of appreciation, such as a handshake or a verbal comment, or could have openly discussed his or her discomfort with kissing patients, while acknowledging this as a cross-cultural difference. Cultural sensitivity would have been communicated in either case.

Therapy Issues and Stereotypes

Two cultural agents are present in every therapeutic dyad. In addition to a focus on the patient's cultural traits, attention must be paid to the ways in which the cultural characteristics of the clinician influence the therapeutic relationship as well as the patient's behavior. This process of "contextualization" of the patient in the clinical dyad can be seen as a two-step approach. First, the clinician may focus on the patient and ask two basic questions: 1) How does the patient's cultural background influence his or her and my behavior? 2) What culturally related assumptions may the patient be making about me? Second, the clinician should ask the following questions: 1) How does my cultural background influence my behavior as well as the patient's? 2) What culturally related assumptions am I making about the patient?

The importance of such bidirectional analytic processes that allow for the clinician's self-assessment should not be underestimated. Clinicians must be open to recognizing that having preconceived assumptions and biases about other individuals and groups is a universal human trait; the forming of attributions and stereotypes is a normative cognitive mechanism essential to our survival. However, deeply ingrained and emotionally driven ethnic, racial, and cultural biases and prejudices have a more self-serving function, such as the release or displacement of frustration and aggression onto others. A clinician's self-reflection and self-assessment are essential in order to decrease the potential negative effect from prejudicial biases and overgeneralized assumptions on his or her assessment and intervention with Latino patients. A serious commitment to the promotion of culturally sensitive clinical competence skills may eventually lead to reducing some of the marked disparities in health care that have been identified with Latinos, as well as with members of other ethnic minority groups in the United States.

The CFI describes a similar process of analyzing both sides of the relationship in supplementary module 8, "Patient-Clinician Relationship," which focuses on the patient's past experiences in treatment, what was helpful and not helpful, and what caused difficulties for the patient. The questions ask patients to reflect on the characteristics they would prefer in their clinician (e.g., age, race, religion), whether they are concerned about potential difficulties between them and the clinician, and the ways in which they may best work together. The module concludes with a self-assessment module for the clinician, which includes questions about how the clinician felt about the therapeutic relationship with the patient and the quality of communication; whether cultural similarities and differences affected the relationship, communication, diagnosis, or treatment plan; whether the clinician identified any preconceived notions about the patient's cultural identity; and whether the clinician's own cultural identity affected his or her attitude toward the patient (American Psychiatric Association 2013) (see Appendix 1, supplementary module 8, pp. 507–509).

Transference and Countertransference: Working With Latino Patients

In analyzing any therapeutic relationship, it is important to discern the displaced or projective nature of transference and countertransference reactions from appropriate responses to actual attitudes that are accurately perceived by either patient or therapist. In other words, not all prejudiced reactions from an

Anglo therapist, or guardedness from a Latino patient, should be considered transferential or countertransferential. Transference reactions that are particular to a given patient must also be discerned from defensive attitudes that may be shared by members of a group given their collective social experience. An example of such shared experiences is the "cultural paranoia" or generalized mistrust toward majority group members that is often observed among members of groups that are victimized in a society, such as ethnic minority groups in the United States, and that may in fact have functional adaptive value (Whaley 2001).

An example of a transference reaction that may be seen in some Latino patients is that of idealizing an Anglo-American therapist in order to ensure the therapist's approval, as an indirect way of seeking acceptance in U.S. mainstream society. Given the general lack of social validation that Latinos receive in U.S. society, such idealization may serve a compensatory function. The patient may go so far as to devalue or underemphasize his or her own cultural values (a type of "ethnic flight") as a way of securing the unequivocal acceptance of the therapist and the mainstream culture. In such cases, the level of agreeability that is expressed by the patient may cause the clinician to inaccurately assess that the patient has established a genuine trusting relationship. However, a patient can also have a true corrective experience through the development of a genuine validating therapeutic relationship, which may result from accurately perceived, as opposed to projected, qualities of the therapist. In the latter case, the patient's therapeutic experience is likely to effect positive changes in his or her life (e.g., improved sense of self-esteem, enhanced social functioning). By contrast, in the former case, if the transference reaction goes unrecognized, the therapist may be puzzled by the patient's lack of progress despite an apparent positive therapeutic experience. In addition to the patient's idealization of the therapist, the patient may projectively identify with the therapist and adopt behaviors or attitudes modeled after the therapist. One way of interpreting such transference reactions is as a way of "identifying with the aggressor," thus attempting to compensate for the general powerlessness an oppressed patient may experience in U.S. society. A related interpretation may be that the patient seeks to identify with feelings of superiority that are projected onto the therapist, thus attempting to compensate for internalized feelings of low social esteem or self-esteem.

The possible transference and countertransference reactions that may emerge with therapists from diverse cultural backgrounds working with Latino patients can be quite varied and complex. Rather than attempting to learn prototypical clinical scenarios, it is more useful for therapists to remain open to exploring the intricate ways in which social and cultural factors can interface with individual elements in the development of transference reactions by patients. Therapists must pay foremost attention to developing an honest, self-reflective openness to exploring their own countertransference reactions. These reactions may either interfere with the therapeutic process or be used for therapeutic growth depending on the therapist's ability to recognize them, analyze them accurately, and manipulate them in accordance with the established therapeutic goals.

Ethnocultural transference and countertransference issues (Comas-Días and Jacobsen 1991) have been discussed in detail in Chapter 1, "Assessment of Culturally Diverse Individuals." The following vignette illustrates a possible scenario that may emerge with a Latino patient.

Case 5

Sergio is an 18-year-old college student who emigrated from Ecuador to the United States with his family at age 12. At his roommate's suggestion, he sought help at the college counseling center because of a recent marked decrease in motivation, difficulty sleeping, and loss of appetite with resulting weight loss. In addition, his academic performance had markedly decreased, and he had become increasingly isolated. He was evaluated at the counseling center, where he received an antidepressant prescription and was assigned to an Anglo-American psychotherapist for treatment of symptoms of depression.

During his initial visits, Sergio spent most of his time describing the difficulty that his parents experienced when he left home and moved out of state to attend college. He made constant references to the cross-cultural differences between his parents and himself, contrasting what he considered the old-fashioned, overprotective, and overdependent style of his Ecuadorean parents with his more "American" values of independence and autonomy. Sergio's manner of relating to the therapist clearly suggested that he believed that the therapist could really understand his conflict, given their "shared American perspective." For example, once while describing his conflict with his parents, he said: "As you and I well know, here in the United States, we see things very differently. We're not as dependent on each other, like my parents and my relatives in Ecuador, who think that children should always stay close to home

to take care of their parents. Here, we're much more independent, and we strongly believe in pursuing our goals, even if it means moving away from family." In addition, he made frequent derogatory jokes caricaturing his parents' culture. The therapist's initial impression was that although Sergio was an immigrant, he showed a high degree of assimilation to U.S. culture. This afforded the therapist the sense that he clearly understood his patient's perspective. The therapist regarded these shared values as instrumental in facilitating the formation of a close therapeutic alliance. He communicated his understanding of Sergio's cross-cultural conflict with his parents and encouraged him to assert his independence and openly express his divergent views to them. Although Sergio continued to act out an empathic identification with the therapist, the therapist became puzzled at Sergio's lack of progress after several months of psychotherapy and psychopharmacological treatment.

One possible way of making sense of the therapeutic impasse is by considering cross-cultural transference and countertransference identifications. Sergio's depression may have been at least partly rooted in an internal cross-cultural conflict resulting from his bicultural experience. As an unconscious strategy to resolve this conflict, he may have split off his culturally grounded ambivalence about moving away from home—which violated Ecuadorean cultural norms—onto his parents. Forming a transference projective identification with his therapist, who represented his more "American" side, facilitated this. However, in doing so, Sergio may have split off the internal core conflict that underlay his depression. The therapist, in a countertransference reaction triggered both by his need to develop a bond with his patient and by his need to be perceived as an effective healer and to reaffirm his own cultural values, encouraged Sergio's "American values" of autonomy and independence. The therapist, in moving quickly to a familiar and comfortable cultural position, may have denied Sergio the opportunity to explore his own ambivalent feelings related to his internal cross-cultural conflict, which would have been necessary to resolve his depression.

Other Important Considerations in the Interaction Between Clinician and Patient

Various cultural values have been emphasized in the social science literature on Latinos, among them *simpatía*, *personalismo*, *respeto*, and *dignidad*, which are discussed in this section. Clinicians should be aware that essentializing Latino cultures into this set of values runs the risk of reductionistic and overly

simplistic cultural stereotyping. Nevertheless, critical discussion of these constructs serves to illustrate certain interpersonal dynamics that clinicians commonly encounter in dealing with Latino patients.

Simpatía translates literally as “sympathy”; however, in Spanish it refers to an expression of likability and agreeability. When a person is *simpático* or *simpática*, he or she has competent and pleasing social skills and is typically well liked. The expression of this social skill is highly valued by most Latino cultures. In a U.S. mainstream cultural setting, however, behaviors that are associated with being *simpático* may often be interpreted as indicative of an overly agreeable and thus nonassertive person. Latinos tend to associate lack of assertiveness not with high agreeability but with shyness, introversion, and limited social skills. Similarly, not being *simpático* in a social situation may be interpreted as rudeness and even lack of generosity. These cultural differences may cause misunderstandings by both clinicians and patients. For example, a Latino patient who behaves in a culturally appropriate pleasant and friendly manner may be wrongly regarded by a U.S. mainstream clinician as lacking assertiveness. Similarly, a Latino patient may misinterpret a U.S. Anglo clinician’s attitude of seriousness and “matter-of-factness” as reflective of a rude, cold, or uncaring individual.

Somewhat related to *simpatía*, the term *personalismo* refers to a preference among many Latinos for direct personal interactions over more indirect practices. Thus, the neutral and reserved stance adopted by some U.S. clinicians may be perceived by some Latino patients as reflective of an excessively cold and aloof individual, hindering the formation of a close therapeutic alliance. In contrast, a Latino patient’s use of handshakes, personal touch, and expressive gestures may be misinterpreted as indicative of someone with poor interpersonal boundaries and inappropriate social distance, as illustrated in the earlier example of culturally appropriate kissing in social situations. Some practices commonly used by clinicians, such as sending letters to remind patients of their appointments, leaving recorded telephone messages, or handing out written educational literature, may seem too formal and impersonal and consequently may not be as effective with Latinos as more direct forms of personal communication (e.g., face-to-face personal communication, having a “live” telephone conversation).

Respeto translates into English as “respect.” However, in Latino cultures it generally has a connotation of much stronger personal significance and emo-

tional weight, characterizing an individual's pride and sense of self-dignity. Consequently, disrespecting someone is typically regarded as a very serious interpersonal violation in Latino cultures, a sort of violation of one's honor. For example, some Latino parents who find out that their adolescent daughter has engaged in sexual relations may regard this event as a *falta de respeto* (literally, "breach of respect") or serious violation of the family's honor. This situation may provoke intense feelings of anger and retaliative behaviors directed toward the daughter's sexual partner (who is seen as a "perpetrator"), as well as strong feelings of disgust toward and rejection of the daughter. Another more subtle illustration of the importance of *respeto* or the related value of *dignidad* (self-dignity) may be the case of Latino patients who feel devalued when they sense that the clinician is making assumptions about their limited educational background and lack of intellectual sophistication (e.g., explaining medical procedures in an overly simplistic fashion or requesting an interpreter after noticing an accent, without adequate assessment of the patient's level of English fluency). These patients, although feeling shamed and disrespected by their clinicians, may engage with them in a culturally appropriate polite and pleasant manner yet fail to return for further appointments.

Overall Cultural Assessment: General Considerations in Assessing Psychopathology Among Latinos

Besides the more specific questions formulated in the CFI to guide the clinical interview, it may be helpful for clinicians to keep four basic questions in mind to help assess for the presence and severity of psychopathology, as well as its etiology, in patients with cultural backgrounds different from those of the clinician or mainstream U.S. society.

1. Are the reported or observed experiences and behaviors considered pathological in the individual's culture of origin?
2. Are they considered pathological in the current social context, including mainstream U.S. society?
3. Are they clearly associated with marked distress or functional impairment?
4. Is the existing distress or impairment caused by individual psychopathology or, rather, by the presence of divergent values and interpretations between the patient, his or her culture, and the host culture?

Four possible scenarios may arise from addressing these questions. First, an individual may report behaviors that are considered pathological both in the culture of origin and in the new context and that cause significant functional impairment. Second, an individual may report a behavior that is considered pathological in the current social context but not in the culture of origin, and there is no evidence of any associated functional impairment. This could be the case with Latinos who report hearing voices or having visions that do not appear to be associated with distress or functional impairment. They may explain these experiences in culturally syntonetic terms as stemming from a special spiritual faculty, such as *espiritista* mediumship, which allows them to be in contact with spirits of the deceased. Such individuals should neither be diagnosed as having a psychiatric (e.g., psychotic or dissociative) disorder nor be treated for these experiences unless it can be clearly established that these experiences are directly causing clinically significant distress or functional impairment.

Third, a situation may arise in which a behavior that is not considered pathological in the culture of origin of the patient is seen as such in the new social context, but there is clear evidence of resulting dysfunction in the new setting. Illustrating this are cases of some Latino parents who use frequent spanking, belting, or other corporal punishment to discipline their children in line with cultural norms, but their behavior is clearly defined in the United States as physical abuse. Such parents may be reported to the appropriate state department that oversees cases of abuse against children, which may result in the child eventually being removed from the home, a process that causes a significant disruption in the family unit and is typically experienced as extremely distressing for both parents and child. Regardless of what ethical or moral position one takes on corporal punishment, it is clear that the resulting dysfunction in this case arises primarily from a divergence in the value systems of the parents and the host culture. This important distinction can lead to very different interventions, such as treatment focused on providing parenting education to caring and well-meaning parents about alternative forms of disciplining their children rather than subjecting them to inappropriate clinical or forensic approaches targeted at malicious perpetrators of physical abuse.

A fourth potential scenario is that of an individual who has a behavior regarded as pathological in the culture of origin but viewed as normal in the new social setting, and the individual experiences significant distress as a result of

this condition. Examples of this are the cases of a Latino man raised in a very traditional environment who experiences homosexual feelings yet chooses not to openly express them and a Latino woman who feels oppressed in her marriage and decides to suppress her wish to leave her husband. In both cases, a clinician with more liberal U.S. values may attempt to normalize these individuals' distress and encourage them to act out their feelings. However, the clinician's priority in such cases should be to validate the patients' genuine distress and assess any pathology or dysfunction resulting from this conflict. Rather than assessing these problems as stemming from internal psychopathology or solely from sociocultural prejudice, a culturally sensitive clinical formulation should account for the sociocultural roots of the problem and emphasize the conflict between individual feelings and cultural values. Intervention should then be directed toward seeking a resolution of this cross-cultural conflict that is satisfactory to the patient rather than toward fixing a defective individual or cultural value or satisfying the clinician's own personal and moral agenda.

Overall Cultural Formulation

The overall cultural formulation takes into account all cultural features and helps the clinician to create a culturally appropriate assessment and treatment plan. In this section we discuss some ways to avoid improper diagnosis and inappropriate treatment.

Misdiagnosis

Latinos are commonly the objects of misdiagnosis. Members of the U.S. mainstream often regard Latinos, as well as many persons from Mediterranean cultures, as overly dramatic and emotional. This should not be surprising, given marked differences in cultural styles of emotional expressiveness observed when comparing Latin and Mediterranean cultures with cultures heavily influenced by white Anglo-Saxon Protestant traditions, such as the white mainstream U.S. culture. However, such purely cross-cultural differences with little relevance to psychopathology may affect diagnostic practice, particularly the valid assessment of affect intensity, and lead to inaccurate assessments of pathological levels of affectivity such as those found in histrionic and borderline personality disorders (Buffenstein 1997; Castillo 1997). Moreover, the

typical gender role-based behaviors of many Latinos and Latinas may be regarded as overly sexually provocative by U.S. mainstream members, and such behaviors may be further confounded with symptoms typical of these character pathologies. For example, it has been noted that certain male behaviors normative in Latino cultures, such as those often associated with the notion of *machismo*, may be confounded with traits of histrionic or narcissistic personality disorder (Castillo 1997; Paniagua 2000).

Differences in culturally shaped affective communication styles, often expressed in children through high levels of physical activity, can also lead to the inaccurate assessment of some Latino children as having disruptive behavior problems or pathological levels of hyperactivity and attentional problems, such as those commonly found in ADHD. Although some cases of hyperactivity and disruptive behaviors may be related to greater psychosocial stress among Latino families and children, the diagnosis of ADHD may also result from changing cultural norms about the containment of emotion and behavior. In either case—pathology caused by psychosocial stress or misdiagnosed culturally patterned behavior—sociocultural factors must be considered in order to achieve an accurate assessment. Evidence also indicates that Latino children are at a higher risk than Anglo children for misdiagnosis of academic difficulties related to limited English proficiency as a learning problem or disability (McCray and Garcia 2002).

Latino children and adults also appear to be at higher risk for overdiagnosis of “antisocial” tendencies typical of conduct disorder and antisocial personality disorder. Certain behaviors with high protective and adaptive value for vulnerable ethnic minority individuals, such as inner-city youths living in settings characterized by poverty, high criminality, and institutionalized social violence, may be inaccurately assessed as pathological in a decontextualized fashion (Buffenstein 1997; Castillo 1997). Normative Latino family dynamics may also be regarded as overdependent, codependent, or enmeshed from the perspective of U.S. mainstream culture, leading to inaccurate assessments of pathological overdependence (Santiago-Rivera et al. 2002). A final example of potential misdiagnosis was mentioned earlier with respect to the misinterpretation and overpathologization of culturally normative perceptual alterations as signs of psychosis, particularly schizophrenia and psychotic depression (Laria 1998; Lewis-Fernández et al. 2003).

In light of these potential clinical misappraisals, it is essential for clinicians to avoid misdiagnosis by becoming aware of the sociocultural aspects affecting the presentation of experience and behavior among Latinos. In particular, valid diagnoses should rely on evidence of distress or impairment as well as accurate clinical attribution of etiology, including the interplay of internal and social factors.

Use of Testing and Assessment Tools With Latinos

The application of standard psychological testing and assessment tools to Latinos raises specialized questions regarding potential misdiagnosis. This topic has been the subject of much controversy and criticism. An extensive review of this area is beyond the scope of this chapter; some general issues have been covered in Chapter 1. However, it may be useful to familiarize clinicians with a few of the major issues involved.

Two major problems in using assessment tools with Latinos are 1) the scarcity of instruments developed specifically to be used with Latino populations and 2) the lack of adequate cross-cultural validation (not just cross-linguistic or semantic equivalence) of many of the standard instruments used with the U.S. mainstream population. Therefore, in the assessment of Latino patients, clinicians are encouraged to use cautiously any information provided by assessment tools and measures that have not been normed specifically with U.S. Latinos and to rely on supplemental clinical information in making important diagnostic and other clinical decisions.

We discuss one test, the Thematic Apperception Test (TAT), as an example of how culture can bias test results and another test that addresses these biases, the TEMAS ("Tell Me A Story"). The TAT is a widely used projective test in which subjects are instructed to create a narrative story in response to pictures that depict subjects interacting in a variety of scenes. The TAT is hypothesized to provide clinically relevant information about a subject's personality traits, such as individual needs, as well as other relational traits. The TAT has been criticized for its cultural and racial bias given the culturally and racially specific characteristics of the individuals, objects, and scenarios that are depicted. In an attempt to challenge the test's validity, a "bottom-up" approach (developing an instrument specifically for a group, rather than adapting an existing instrument to a group different from the one for which it was originally

developed) was used in the development of the TEMAS (Costantino et al. 1988). The TEMAS depicts scenes with Latino characters using cultural themes in urban settings that are more relevant to U.S. Latinos.

Studies comparing the TAT with the TEMAS report that Latinos show greater responsiveness and verbal fluency when given the TEMAS. These traits are interpreted as suggestive of greater sophistication and maturity in interpersonal relationships. Another interesting finding is that bilingual subjects tend to create stories in English with the TAT and to switch from English to Spanish with the TEMAS (Costantino et al. 1981), which evidences the complexity involved in using these measures with Latinos.

A variety of psychiatric symptom rating scales have been translated into Spanish and used extensively with Latino patients, such as the Hopkins Symptom Checklist-90 (SCL-90) and its shorter version, the Brief Symptom Inventory (Sánchez-Lacay et al. 2001); the Beck Depression Inventory (Bonilla et al. 2004); the Brief Psychiatric Rating Scale (Hafkenscheid 1991); the Patient Health Questionnaire (Wulsin et al. 2002); and the Psychiatric Research Interview for Substance and Mental Disorders (PRISM) (Torrens et al. 2004). Although there is some support for their applicability with Latinos, clinicians are encouraged to use these instruments with caution, given that they were originally developed for mainstream U.S. samples.

Empirically Based Psychosocial Interventions

Little research has been done on the efficacy of specific mental health interventions with Latinos (Bernal and Sáez-Santiago 2006; Bernal and Scharrón-del-Río 2001; Whaley and Davis 2007). Limited preliminary efficacy has been found for CBT, interpersonal psychotherapy, and behavior therapy with depressed Latino women (Comas-Díaz 1981; Miranda et al. 2003; Rosselló and Bernal 1999). However, most of these studies have been conducted primarily with women of Puerto Rican or Mexican origin. Some studies have focused on family therapy with Latinos. Weisman (2005) proposed a “culturally informed therapy for schizophrenia” based on evidence that strongly supports the integration of culturally based treatment approaches with existing psychoeducational family-focused interventions with Latino patients and families coping with schizophrenia. Canino and Canino (1982) used an ecostructural family therapy approach and a systems-oriented family therapy approach with

low-income Puerto Rican migrants and found these modalities to be both culturally syntonetic and effective with this population. Szapocznik et al. (1989) tested cultural adaptations of both strategic family therapy and structural family therapy and found these interventions to be highly effective for Latino adolescents with drug-related behavioral and emotional problems.

Other studies have suggested a variety of culturally relevant strategies that can be effectively implemented with Latinos. These include *cuento* therapy (storytelling using native cultural stories and characters) (Costantino et al. 1986); using *dichos* and *refranes* as central points in therapy (Aviera 1996); culturally relevant modeling therapy (Malgady et al. 1990a); using folk heroes as experience-near behavioral models (Malgady et al. 1990b); culturally relevant images (Bracero 1998); and focusing therapy on the relation between cultural idioms of distress and politically rooted psychosocial factors, such as anger and injustice (Rogler et al. 1994).

Bernal and Sáez-Santiago (2006) highlighted the limited available evidence for effective interventions with Latinos and emphasized the need to consider cultural and other contextual factors in treating Latinos. They proposed a model that includes elements or dimensions that must be incorporated to “culturally center” a psychosocial intervention. These strategies constitute promising approaches to culturally relevant forms of therapy and should be tested further with more rigorous research designs. In conclusion, clinicians must rely on cultural knowledge, culturally sensitive assessment procedures, flexibility with existing protocols, and creativity in designing and carrying out culturally relevant mental health interventions with Latinos. For example, the treatment for patients meeting DSM-5 criteria for *ataques* should focus on helping the patient to manage the distressing situations that provoked the episodes as well as on treating the associated psychopathology, which may be distinct in each case.

Conclusion

Understanding Latinos requires an appreciation of the group’s commonalities as well as the wide range of individual and group variations observed among members of the various Latino cultures. Clearly, seeking treatment adherence and effective intervention with Latino patients requires the provision of men-

tal health services that have relevance to them. Culturally sensitive assessment and presentation of therapeutic options are essential in this process, such as what can be obtained by consistent use of the DSM-5 Outline for Cultural Formulation model. Patients are not likely to engage in lengthy mental health interventions that lack practical relevance and run counter to their culturally informed understandings and expectations of how illness should be assessed and treated. The video excerpts of the interview (Videos 5-1, 5-2, and 5-3) provide a good illustration of some of the culturally competent skills that the clinician can use with a Latino patient.

We have offered other suggestions for how to avoid various pitfalls in the treatment of Latino patients, such as avoiding simplistic stereotypes and a priori or precipitous assumptions, as well as exercising caution with the potential misinterpretation of culturally normative behaviors. Direct personal relatedness and perceived clinician warmth emerge as key variables in promoting the therapeutic alliance and participation of Latino patients. In addition, given the centrality of the family in Latino cultures, attention to family matters is essential for an accurate assessment of a patient's problems. Active engagement of family members in treatment, when appropriate, can be a very effective intervention.

Practical barriers to treatment, such as financial limitations and transportation or work-related difficulties, also need to be addressed and discerned from lack of motivation for treatment. Whenever these are present, efforts should be made to help patients attempt to resolve them. Clinicians are encouraged to rely as much as possible on cultural knowledge, flexibility, and creativity in adapting existing therapeutic models with Latino patients. They should also take into account some of the significant differences in cultural concepts, values, and normative behaviors discussed. It is hoped that future research will provide us with much-needed knowledge of empirically based interventions that work effectively with Latinos. In the meantime, attention to three basic elements that underlie the cultural formulation model and the CFI, namely, awareness of, sensitivity to, and appreciation of cultural differences, can guide clinicians in designing competent strategies that yield effective results with their Latino patients.

References

- Alegría M, Takeuchi D, Canino G, et al: Considering context, place and culture: the National Latino and Asian American Study. *Int J Methods Psychiatr Res* 13(4):208–220, 2004
- Alegría M, Mulvaney-Day N, Torres M, et al: Prevalence of psychiatric disorders across Latino subgroups in the United States. *Am J Public Health* 97(1):68–75, 2007
- American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition. Washington, DC, American Psychiatric Association, 1994
- American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000
- American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition. Washington, DC, American Psychiatric Association, 2013
- Angel J: Nuestros padres: elder care in Hispanic families. *Hispanic* 11:18–23, 1998
- Aviera A: “Dichos” therapy group: a therapeutic use of Spanish language proverbs with hospitalized Spanish-speaking psychiatric patients. *Cult Divers Ment Health* 2(2):73–87, 1996
- Bernal G, Sáez-Santiago E: Culturally centered psychosocial interventions. *J Community Psychol* 34:121–132, 2006
- Bernal G, Scharrón-del-Río MR: Are empirically supported treatments valid for ethnic minorities? Toward an alternative approach for treatment research. *Cult Divers Ethnic Minor Psychol* 7(4):328–342, 2001
- Bonilla J, Bernal G, Santos A, et al: A revised Spanish version of the Beck Depression Inventory: psychometric properties with a Puerto Rican sample of college students. *J Clin Psychol* 60(1):119–130, 2004
- Bracero W: Intimidades: confianza, gender, and hierarchy in the construction of Latino-Latina therapeutic relationships. *Cult Divers Ment Health* 4(4):264–277, 1998
- Buffenstein A: Personality disorders, in *Culture and Psychopathology: A Guide to Clinical Assessment*. Edited by Tseng W, Streltzer J. New York, Brunner/Mazel, 1997, pp 190–205
- Brabera L: El Monte, Igbo, Finda, Ewe Orisha, Vititi Nfinda: Notas Sobre las Religiones, la Magia, las Supersticiones y el Folklore de los Negros Criollos y el Pueblo de Cuba. Miami, FL, Ediciones Universal, 1992
- Canino G, Canino IA: Culturally syntonc family therapy for migrant Puerto Ricans. *Hosp Community Psychiatry* 33(4):299–303, 1982
- Canino G, Roberts RE: Suicidal behavior among Latino youth. *Suicide Life Threat Behav* 31(suppl):122–131, 2001

- Canino G, Bird HR, Shrout PE, et al: The prevalence of specific psychiatric disorders in Puerto Rico. *Arch Gen Psychiatry* 44(8):727–735, 1987
- Castillo RJ: *Culture and Mental Illness: A Client-Centered Approach*. Pacific Grove, CA, Brooks/Cole, 1997
- Cheung FK, Snowden LR: Community mental health and ethnic minority populations. *Community Ment Health J* 26(3):277–291, 1990
- Comas-Díaz L: Effects of cognitive and behavioral group treatment on the depressive symptomatology of Puerto Rican women. *J Consult Clin Psychol* 49(5):627–632, 1981
- Comas-Díaz L, Jacobsen FM: Ethnocultural transference and countertransference in the therapeutic dyad. *Am J Orthopsychiatry* 61(3):392–402, 1991
- Costantino G, Malgady R, Vazquez C: A comparison of the Murray-TAT and a new Thematic Apperception Test for urban Hispanic children. *Hisp J Behav Sci* 3:291–300, 1981
- Costantino G, Malgady RG, Rogler LH: Cuento therapy: a culturally sensitive modality for Puerto Rican children. *J Consult Clin Psychol* 54(5):639–645, 1986
- Costantino G, Malgady R, Rogler L: *Technical Manual: TEMAS Thematic Apperception Test*. Los Angeles, CA, Western Psychological Services, 1988
- Eaton DK, Kann L, Kinchen S, et al: Youth risk behavior surveillance—the United States, 2007. *MMWR Surveill Summ* 57(4):1–131, 2008
- Eaton DK, Kann L, Kinchen S, et al: Youth risk behavior surveillance—United States, 2001. *MMWR Surveill Summ* 61(4):1–162, 2012
- Escobar JI: Cross-cultural aspects of the somatization trait. *Hosp Community Psychiatry* 38(2):174–180, 1987
- Escobar JI, Vega WA: Mental health and immigration's AAAs: where are we and where do we go from here? *J Nerv Ment Dis* 188(11):736–740, 2000
- Escobar JI, Hoyos Nervi C, Gara MA: Immigration and mental health: Mexican Americans in the United States. *Harv Rev Psychiatry* 8(2):64–72, 2000
- Farías P: Central and South American refugees: some mental health challenges, in *Amidst Peril and Pain: The Mental Health and Well-Being of the World's Refugees*. Edited by Marsella AJ, Bornemann T, Ekblad S, et al. Washington, DC, American Psychological Association, 1994, pp 101–113
- Glover SH, Pumariega AJ, Holzer CE, et al: Anxiety symptomatology in Mexican American adolescents. *J Child Fam Stud* 8:47–57, 1999
- Guarnaccia PJ, Rodriguez O: Concepts of culture and their role in the development of culturally competent mental health services. *Hisp J Behav Sci* 18:419–443, 1996
- Hafkenscheid A: Psychometric evaluation of a standardized and expanded Brief Psychiatric Rating Scale. *Acta Psychiatr Scand* 84:294–300, 1991

- Harker K: Immigrant generation, assimilation, and adolescent psychological well-being. *Soc Forces* 79:969–1004, 2001
- Harwood A (ed): *Ethnicity and Medical Care*. Cambridge, MA, Harvard University Press, 1981
- Harwood A: *Rx: Spiritist as Needed: A Study of a Puerto Rican Community Mental Health Resource*. Ithaca, NY, Cornell University Press, 1987
- Hernandez DJ, Charney E: *From Generation to Generation: The Health and Well-Being of Children in Immigrant Families*. Washington, DC, National Academy Press, 1998
- Hohmann AA, Richeport M, Marriott BM, et al: Spiritism in Puerto Rico: results of an island-wide community study. *Br J Psychiatry* 156:328–335, 1990
- Interian A, Lewis-Fernández R, Dixon L: Improving treatment engagement of underserved U.S. racial-ethnic groups: a review of recent interventions. *Psychiatr Serv* 64:212–222, 2013
- Kessler RC, McGonagle KA, Zhao S, et al: Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: results from the National Comorbidity Survey. *Arch Gen Psychiatry* 51(1):8–19, 1994
- Kirmayer LJ, Young A: Culture and somatization: clinical, epidemiological, and ethnographic perspectives. *Psychosom Med* 60(4):420–430, 1998
- Kleinman A: *Patients and Healers in the Context of Culture*. Berkeley, University of California Press, 1980
- Kouyoumdjian H, Zamoanga BL, Hansen DJ: Barriers to community mental health services for Latinos: treatment considerations. *Clinical Psychology: Science and Practice* 10:394–422, 2003
- Laria AJ: *Dissociative experiences among Cuban mental health patients and spiritist mediums*. Doctoral dissertation, University of Massachusetts, Boston, MA, 1998
- Lewis-Fernández R: *Mental health disparities in the Hispanic population*. Paper presented at CME conference, University of Arizona College of Medicine, Tucson, January 2003
- Lewis-Fernández R, Blanco C, Schmidt A, et al: Assessing psychosis screeners among underserved urban primary care patients. Paper presented at the annual meeting of NARSAD (National Association for Research on Schizophrenia and Depression), New York, October 18, 2003
- Lewis-Fernández R, Das A, Alfonso C, et al: Depression in US Hispanics: diagnostic and management considerations in family practice. *J Am Board Fam Med* 18(4):282–296, 2005
- Lewis-Fernández R, Horvitz-Lennon M, Blanco C, et al: Significance of endorsement of psychotic symptoms by US Latinos. *J Nerv Ment Dis* 197(5):337–347, 2009

- Lewis-Fernández R, Gorritz M, Raggio GA, et al: Association of trauma-related disorders and dissociation with four idioms of distress among Latino psychiatric outpatients. *Cult Med Psychiatry* 34(2):219–243, 2010
- Lewis-Fernández R, Balán IC, Patel SR, et al: Impact of motivational pharmacotherapy on treatment retention among depressed Latinos. *Psychiatry* 76:210–222, 2013
- López SR: A research agenda to improve the accessibility and quality of mental health care for Latinos. *Psychiatr Serv* 53(12):1569–1573, 2002
- Malgady RG, Costantino G: Symptom severity in bilingual Hispanics as a function of clinician ethnicity and language of interview. *Psychol Assess* 10(2):120–127, 1998
- Malgady RG, Rogler LH, Costantino G: Culturally sensitive psychotherapy for Puerto Rican children and adolescents: a program of treatment outcome research. *J Consult Clin Psychol* 58(6):704–712, 1990a
- Malgady RG, Rogler LH, Costantino G: Hero/heroine modeling for Puerto Rican adolescents: a preventive mental health intervention. *J Consult Clin Psychol* 58(4):469–474, 1990b
- Marcos LR, Uruyo L, Kesselman M, et al: The language barrier in evaluating Spanish-American patients. *Arch Gen Psychiatry* 29(5):655–659, 1973
- Marin G, Triandis HC: Allocentrism as an important characteristic of the behavior of Latin Americans and Hispanics, in *Cross-Cultural and National Studies in Social Psychology*. Edited by Diaz-Guerrero R. Amsterdam, North-Holland, 1985, pp 85–104
- McCray AD, Garcia SB: The stories we must tell: developing a research agenda for multicultural and bilingual special education, in *Multicultural and Bilingual Special Education: A Case for Socioculture Contexts and Voices in Research and Practice* (special issue). *International Journal of Qualitative Studies in Education* 15:599–612, 2002
- Miranda J, Azocar F, Organista KC, et al: Recruiting and retaining low-income Latinos in psychotherapy research. *J Consult Clin Psychol* 64(5):868–874, 1996
- Miranda J, Chung JY, Green BL, et al: Treating depression in predominantly low-income young minority women: a randomized controlled trial. *JAMA* 290(1):57–65, 2003
- Miranda MR, Andujo E, Guerrero CC, et al: Mexican American dropouts in psychotherapy as related to level of acculturation, in *Psychotherapy With the Spanish-Speaking: Issues in Research and Service Delivery*. Edited by Miranda MR. Los Angeles, University of California Press, 1976, pp 35–50

- Morales E: Gender roles among Latino gay and bisexual men: implications for family and couple relationships, in *Lesbians and Gays in Couples and Families: A Handbook for Therapists*. Edited by Laird J, Green RJ. San Francisco, CA, Jossey-Bass, 1996, pp 272–297
- Moscicki EK, Rae D, Regier DA, et al: The Hispanic Health and Nutrition Examination Survey: depression among Mexican Americans, Cuban Americans, Puerto Ricans, in *Health and Behavior: Research Agenda for Hispanics*. Edited by Gaviria M, Arana JD. Chicago, Publication Services of the University of Illinois, 1987
- Olson M, Lewis-Fernández R, Weissman MM, et al: Psychotic symptoms in an urban general medicine practice. *Am J Psychiatry* 159(8):1412–1419, 2002
- Oquendo MA, Ellis SP, Greenwald S, et al: Ethnic and sex differences in suicide rates relative to major depression in the United States. *Am J Psychiatry* 158(10):1652–1658, 2001
- Padgett DK, Patrick C, Burns BJ, et al: Ethnicity and the use of outpatient mental health services in a national insured population. *Am J Public Health* 84(2):222–226, 1994
- Paniagua FA: Culture-bound syndromes, cultural variations, and psychopathology, in *Handbook of Multicultural Mental Health*. Edited by Cuellar I, Paniagua FA. San Diego, CA, Academic Press, 2000, pp 139–169
- Parrillo VN: *Strangers to These Shores: Race and Ethnic Relations in the United States*, 8th Edition. Boston, MA, Allyn & Bacon, 2005
- Peña JB, Wyman PA, Brown CH, et al: Immigration generation status and its association with suicide attempts, substance use, and depressive symptoms among Latino adolescents in the USA. *Prev Sci* 9(4):299–310, 2008
- Pew Research Center: Median Age for Hispanics is Lower Than Median Age for Total U.S. Population. Washington, DC, Pew Research Center, 2012. Available at: <http://www.pewresearch.org/daily-number/median-age-for-hispanics-is-lower-than-median-age-for-total-u-s-population>. Accessed May 11, 2014.
- Pew Research Center: Ranking Latino Population in the States. Washington, DC, Pew Research Center, 2013a. Available at: <http://www.pewhispanic.org/2013/08/29/ii-ranking-latino-populations-in-the-states>. Accessed May 12, 2014.
- Pew Research Center: Hispanics of Puerto Rican Origin in the United States 2011 (June 19, 2013). Washington, DC, Pew Research Center, 2013b. Available at: <http://www.pewhispanic.org/2013/06/19/hispanics-of-puerto-rican-origin-in-the-united-states-2011>. Accessed May 13, 2014.

- Pew Research Center: Statistical Portrait of Hispanics in the United States, 2012 (April 29, 2014). Washington, DC, Pew Research Center, 2014a. Available at: <http://www.pewhispanic.org/2014/04/29/statistical-portrait-of-hispanics-in-the-united-states-2012/#detailed-hispanic-origin-2012/>. Accessed May 12, 2014.
- Pew Research Center: The Shifting Religious Identity of Latinos in the United States. Washington, DC, Pew Research Center, 2014b. Available at: <http://www.pewforum.org/2014/05/07/chapter-1-religious-affiliation-of-hispanics>. Accessed May 13, 2014.
- Phinney JS, Kohatsu EL: Ethnic and racial identity development and mental health, in *Health Risks and Developmental Transitions During Adolescence*. Edited by Schulenberg J, Maggs JL. New York, Cambridge University Press, 1997, pp 420–443
- Portes A, Rumbaut RG: *Immigrant America: A Portrait*. Berkeley, University of California Press, 1996
- Potochnick SR, Perreira KM: Depression and anxiety among first-generation immigrant Latino youth: key correlates and implications for future research. *J Nerv Ment Dis* 198(7):470–477, 2010
- Price CS, Cuellar I: Effects of language and related variables on the expression of psychopathology in Mexican-American psychiatric patients. *Hisp J Behav Sci* 3:145–160, 1981
- Roberts RE, Roberts CR, Xing Y: Prevalence of youth-reported DSM-IV psychiatric disorders among African, European, and Mexican American adolescents. *J Am Acad Child Adolesc Psychiatry* 45(11):1329–1337, 2006
- Rodriguez CE: *Puerto Ricans: Born in the U.S.A.* Boulder, CO, Westview, 1991
- Rogg EM, Cooney RS: *Adaptation and Adjustment of Cubans*. West New York, New Jersey. Monograph No 5.101. Bronx, NY, Hispanic Research Center, Fordham University, 1980
- Rogler LH: Research on mental health services for Hispanics: targets of convergence. *Cult Divers Ment Health* 2(3):145–156, 1996
- Rogler LH, Cortes DE, Malgady RG: The mental health relevance of idioms of distress: anger and perceptions of injustice among New York Puerto Ricans. *J Nerv Ment Dis* 182(6):327–330, 1994
- Rosenberg JC: *El Gagá: Religión y Sociedad de un Culto Dominicano: Un Estudio Comparativo*. Santo Domingo, Dominican Republic, Universidad Autónoma de Santo Domingo, 1979
- Rosselló J, Bernal GL: The efficacy of cognitive-behavioral and interpersonal treatments for depression in Puerto Rican adolescents. *J Consult Clin Psychol* 67(5):734–745, 1999

- Sabogal F, Marín G, Otero-Sabogal R, et al: Hispanic familism and acculturation: what changes and what doesn't? *Hisp J Behav Sci* 9:397–412, 1987
- Saluja G, Iachan R, Scheidt PC, et al: Prevalence of and risk factors for depressive symptoms among young adolescents. *Arch Pediatr Adolesc Med* 158(8):760–765, 2004
- Sánchez-Lacay JA, Lewis-Fernández R, Goetz D, et al: Open trial of nefazodone among Hispanics with major depression: efficacy, tolerability, and adherence issues. *Depress Anxiety* 13(3):118–124, 2001
- Santiago-Rivera AL, Arredondo P, Gallardo-Cooper M: *Counseling Latinos and la Familia: A Practical Guide*. Thousand Oaks, CA, Sage, 2002
- Shrout PE, Alegría M, Canino G, et al: Testing language effects in psychiatric epidemiology surveys with randomized experiments: results from the National Latino and Asian American Study. *Am J Epidemiol* 168(3):345–352, 2008
- Suarez-Orozco C, Suarez-Orozco MM: *Transformations: Immigration, Family Life, and Achievement Motivation Among Latino Adolescents*. Stanford, CA, Stanford University Press, 1995
- Szapocznik J, Rio A, Murray E, et al: Structural family versus psychodynamic child therapy for problematic Hispanic boys. *J Consult Clin Psychol* 57(5):571–578, 1989
- Teplin LA: Psychiatric and substance abuse disorders among male urban jail detainees. *Am J Public Health* 84(2):290–293, 1994
- Torrens M, Serrano D, Astals M, et al: Diagnosing comorbid psychiatric disorders in substance abusers: validity of the Spanish versions of the Psychiatric Research Interview for Substance and Mental Disorders and the Structured Clinical Interview for DSM-IV. *Am J Psychiatry* 161(7):1231–1237, 2004
- Trestman RL, Ford J, Zhang W, et al: Current and lifetime psychiatric illness among inmates not identified as acutely mentally ill at intake in Connecticut's jails. *J Am Acad Psychiatry Law* 35(4):490–500, 2007
- U.S. Census Bureau: *The Hispanic Population: 2010 Census Briefs*. Washington, DC, U.S. Census Bureau, 2011. Available at: <http://www.census.gov/prod/cen2010/briefs/c2010br-04.pdf>. Accessed May 12, 2014.
- U.S. Census Bureau: *The Hispanic Population in the US: 2012*. Washington, DC, U.S. Census Bureau, 2012. Available at: <http://www.census.gov/population/hispanic/data/2012.html>. Accessed May 12, 2014.
- U.S. Census Bureau: *Income, Hispanic Heritage Month 2013: Sept. 15–Oct. 15. Profile America Facts for Features (CB13-FF.19, July 30, 2013)*. Washington, DC, U.S. Census Bureau, 2013a. Available at: http://www.census.gov/newsroom/releases/archives/facts_for_features_special_editions/cb13-ff19.html. Accessed May 12, 2014.

- U.S. Census Bureau: Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2012. Washington, DC, U.S. Census Bureau, 2013b. Available at: http://www.census.gov/newsroom/releases/pdf/PEP_2012_PEPAGESEX.pdf. Accessed May 22, 2014.
- U.S. Census Bureau: Income, Poverty, and Health Insurance Coverage in the United States: 2012. Current Population Reports (P60-245, September 2013). Washington, DC, U.S. Census Bureau, 2013c. Available at: <http://www.census.gov/prod/2013pubs/p60-245.pdf>. Accessed May 13, 2014.
- U.S. Census Bureau: Race Reporting Among Hispanics: 2010. (Working Paper No 102). Washington, DC, U.S. Census Bureau, 2014. Available at: <http://www.census.gov/population/www/documentation/twps0102/twps0102.pdf>. Accessed May 22, 2014.
- U.S. Department of Health and Human Services: Mental Health: Culture, Race, and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD, U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General, 2001. Available at: <http://www.ncbi.nlm.nih.gov/books/NBK44243/>. Accessed May 22, 2014.
- U.S. Department of Homeland Security, Office of Immigration Statistics: Estimates of the Unauthorized Immigrant Population Residing in the United States: January 2011. Washington, DC, U.S. Department of Homeland Security, 2012
- Vazsonyi AT, Flannery D: Early adolescent delinquent behaviors: associations with family and school domains. *J Early Adolesc* 17:271–293, 1997
- Vega WA, Scribney WM: Understanding the Hispanic health paradox through a multi-generation lens: a focus on behavior disorders, in *Health Disparities in Youth and Families*. Edited by Carlo G, Crockett L, Carranza M. New York, Springer, 2011, pp 151–168
- Vega WA, Karno M, Alegria M, et al: Research issues for improving treatment of U.S. Hispanics with persistent mental disorders. *Psychiatr Serv* 58(3):385–394, 2007
- Vega WA, Canino G, Cao Z, et al: Prevalence and correlates of dual diagnoses in U.S. Latinos. *Drug Alcohol Depend* 100(1–2):32–38, 2009
- Vera M, Alegría M, Freeman D, et al: Depressive symptoms among Puerto Ricans: island poor compared with residents of the New York City area. *Am J Epidemiol* 134(5):502–510, 1991
- Weisman A: Integrating culturally based approaches with existing interventions for Hispanic/Latino families coping with schizophrenia. *Psychotherapy* 42(2):178–197, 2005
- Whaley AL: Cultural mistrust: an important psychological construct for diagnosis and treatment of African Americans. *Prof Psychol Res Pr* 32:555–562, 2001

- Whaley AL, Davis KE: Cultural competence and evidence-based practice in mental health services: a complementary perspective. *Am Psychol* 62(6):563–574, 2007
- Wulsin L, Somoza E, Heck J: The feasibility of using the Spanish PHQ-9 to screen for depression in primary care in Honduras. *Prim Care Companion J Clin Psychiatry* 4(5):191–195, 2002

This page intentionally left blank

Issues in the Assessment and Treatment of American Indian and Alaska Native Patients

Candace M. Fleming, Ph.D.

Russell F. Lim, M.D., M.Ed.

The non-Native mental health clinician sat down at his work computer at the start of his day. He noted that his first patient was affiliated with one tribal nation recognized by the U.S. federal government and a second tribe recognized by a neighboring state. His response was high interest mixed with apprehension. He had recently completed his agency's cultural competence training for the quarter, but those particular tribes were not featured in any of the specific examples. He clicked to the paraprofessional's intake summary and reviewed her summary of the Native Assessment of Functioning. The tool assessed the strengths and challenges of a Native person in five realms of living: physical, emotional, intellectual, spiritual, and social. What emerged from the descriptions across domains gave the clinician an initial idea of how this Na-

tive individual might be negotiating the various Native and non-Native circumstances of life in the region.

The intake information suggested that the patient was fairly bicultural and was open to both mainstream and Native-specific approaches to mental health intervention. The clinician wondered what evidence-based practices had been shown to work with the tribal nations with whom this patient was affiliated. A quick query of the evidence-based database found that mental health and substance use research had not yet been completed with the cultural groups of the two tribal nations, but there were several published articles written by providers working in Native communities that described promising practices. The clinician smiled to himself. He would enter the therapeutic relationship with this Native person very aware of the high complexity of the patient's experiences. The immediate need to know more was in sharp contrast with his slowly growing knowledge about Native people. However, the paraprofessionals, scientists, and practitioners working with Native patients provided some valuable information that would help him convey respect and understanding to this new patient. "Another chance to learn," he told himself as he got up to greet his first patient of the day.

The vignette above is presented as if it happened in the past, but the advances in assessment, intervention, service system development, and training suggested by the brief story are very much in the future for North America's indigenous populations. Evidence-based practices for Native Americans are not available in large numbers and do not meet the standards of evidence-based practices (Gone and Alcántara 2007). Reliable knowledge about these populations and their distinctive place in American life is difficult to come by. The mental health services provider in the United States typically does not have personal or professional connections with indigenous populations and obtains information from books, films, television programming, and the occasional newspaper article.

Sadly, indigenous perspectives on life views, philosophy, history, and contemporary issues are missing from these popular venues of information. Thus, it is usually left to the patient to bring his or her individual, family, and cultural perspectives to the mental health setting. Indian patients, while quite aware of the various stereotypical characterizations that are held by non-Indians about Indians, may not be accustomed to describing the various individual, family, clan, tribal, and pan-Indian perspectives and distinguishing them from each

other. Therefore, in this chapter, we provide the clinician with basic social and historical information on which to build his or her understanding of Indian patients and partnership with cultural consultants. Unfortunately, the field does not yet have a Native Assessment of Functioning, but we nonetheless provide some guidelines on the assessment and treatment of Native Americans with mental illness.

Information and perspectives are offered here to show the effect of cultural issues on assessment, diagnosis, and intervention with American Indians and Alaska Natives who have behavioral health disorders or, in words that resonate more with the Native person, are in a state of distress or imbalance within the intrapersonal realm (thought, emotion, behavior), within one or more interpersonal relationships, or within a spiritual relationship with spiritual deities or other parts of creation.

The DSM-5 Outline for Cultural Formulation (OCF; American Psychiatric Association 2013) provides the framework for summarizing what has been said by mental health and substance abuse treatment providers, prevention specialists, researchers, community development specialists, policy makers, and Indian/Native community members about the provision of effective and culturally relevant mental health services to Indians and Natives. We also discuss the use of the Cultural Formulation Interview (CFI), included in DSM-5, which was developed from the OCF and provides the clinician with a 16-question interview outline, along with 12 supplementary modules and an informant module on different aspects of the patient's history (American Psychiatric Association 2013). We also highlight where knowledge development needs to be done in basic science, epidemiology and needs assessment, intervention research and evaluation, and the sharing of promising practices across Indian and Native communities.

There are many terms of reference for the indigenous populations of North America, including *American Indians*, *Alaska Natives*, *Native Americans*, *Native Indians*, *Native American Indians*, *Indians*, *Natives*, and *First Nations*. Each term is useful, depending on the historical, societal, and political nature of the setting. The terms *Indian* and *Native* are used in this chapter for expedience, but it is far more preferable to use an individual's specific tribal or village name as a group reference.

Current Status

In the 2010 U.S. Census, 5.3 million citizens identified themselves as American Indian or Alaska Native (AIAN) either as their only race or in combination with other designations. This is less than 1.75% of the total U.S. population (Norris et al. 2010), but it represents an exceptional increase for this population from previous census enumerations, with a growth rate of 26.9% compared with the growth rate of the majority population at 9.8%. The growth is due to several major factors: better data collection by the U.S. Census Bureau, greater willingness to report Native ancestry, higher birth rate, and reduced infant mortality. “Indian Country” is generally believed to be the West, and, indeed, the data bear this out: most Indians live in Western states, and the top 10 states are California, Arizona, Oklahoma, Texas, New York, New Mexico, Washington, North Carolina, Florida, and Michigan, and 42% reside in rural areas (Rural Policy Research Institute 1997). Many reservations and trust lands (areas with boundaries established by treaty, statute, or executive or court order) exist for Indian nations, but currently only one in five Indians lives in these areas. The majority of the AIAN alone or in combination population (78%) lives outside of AIAN areas (reservations or trust lands) (U.S. Census Bureau 2010), and most maintain close family and political ties with reservation and trust land communities.

From the beginning of contact with Europeans, the original peoples of North America were almost exclusively viewed as homogeneous, and this stereotype prevails today; in the minds of many Americans, high cheekbones and tepee dwellings are the hallmarks of every indigenous person. Trimble and Thurman (2002) present a compelling explanation for the 400-year transformation of North America’s original populations from multiple groups of peoples with little in common with non-Native Americans to one of the United States’ four officially recognized ethnic minority groups. As with other racial/ethnic populations, the Indian group has considerable heterogeneity.

Much of the heterogeneity is a result of the several environments that indigenous peoples have lived in and adapted to over the centuries. Indigenous groups that shared environments tended to develop similar skills, knowledge, beliefs, and customs. The different geographic regions have defined North American Indian cultural areas that are unique and complex: Arctic, Subarctic, Plateau, Northwest Coast, California, Great Basin, Southwest, Plains,

Northeast, and Southeast (Waldman 1985). Indian language families (Algonquian, Athapaskan, Siouan, Iroquoian, and Eskimo-Aleut) are another hallmark of diversity. Scholars estimate that at the beginning of European colonization of North America, there were between 200 and 300 distinct Native languages spoken. Sadly, more than half of these languages are now extinct, and another large set is nearly extinct. The transmission of the nuances of cultural beliefs and ways is severely compromised when a native language is known by only a few people within an Indian community, and the recognition of this has led to the establishment of literacy in Native language as a high priority for contemporary tribal nations.

With the formation of the United States, the federal government began to establish treaties with individual tribes and groups of tribes, but the uniqueness of each tribal nation was underplayed when it came to federal policies that largely considered American Indians as a single entity. Sovereign nation status has been given to 566 tribal entities by the U.S. federal government (National Congress of American Indians 2013), and hundreds more are recognized by state governments. Sovereignty for each tribal group and the right of each group to be treated as having unique strengths and challenges are central issues that today pervade every aspect of tribal life, including health and mental health.

Historical Issues That Relate to Mental Health

Many historical events affect our relationships with Native American patients—warfare between grossly unmatched opponents, massacres of entire villages, disease epidemics, trickery in treaty making, forced removal from ancestral lands, and shrinking land base due to theft, land runs, and sales by impoverished and ill Indian wards of the federal government. This is just a partial list of major historical traumas and losses endured by Indians and Natives. It is vital to know the history from the Native point of view; one readable and well-documented resource is *The Complete Idiot's Guide to Native American History* (Fleming 2003). The concept of the “Vanishing Red Man” was close to becoming a reality in the early 1900s, the point when Indians and Natives numbered only 5% of their estimated population of 400 years earlier (Thornton 1987).

Today this group is growing fast and in some ways is thriving. The incredible resiliency of Indian people and tribes must be acknowledged and celebrated. Subjugation of Indian and Native beliefs and practices that could have assisted with recovery from traumas, losses, and rapid societal change was thorough and happened through a variety of means, beginning with the isolation and neglect of Indians on reservations and other trust lands. The beginning of the reservation system coincided with the California gold rush of the 1840s and 1850s, when wagon trains crossed Indian lands, increasing hostility toward Western tribes. Peacemaking was attempted with treaties in which tribal territories were defined, but the defining process resulted in the loss of millions of acres of Indian lands to the U.S. government. The redefined territories, called reservations, were not lands given to Indians by the non-Indian government but lands that Indians were allowed to retain. Often the homelands were not well understood by the Indians, and virtually no technical support was given to build up tribal human resources to effectively adapt to the natural resources within the reservation boundaries. Violence against Native traditions in the form of enforced bans on traditional Indian objects and ways was commonplace. It is no wonder that cycles of poverty, societal disorder, and ill health have resulted from the reservation system. On the other hand, the reservation was a cradle for nurturing intense belonging to the tribal unit and connection to the beloved homeland.

Educational systems, most notably those established by religious institutions and the federal government, were another means for drastically eroding Indian cultures. Education of Indian youth was considered a solution to the "Indian problem," with the goal being to Christianize and civilize Indians. The federal boarding school system (often off-reservation) began in 1879, and for decades, children were taken from their families for months or years at a time. Their outward appearance (hairstyle and clothing) was changed to meet the military school atmosphere or the standards of the day, and to diminish their psychological, emotional, and spiritual identity with their tribal people, they were punished for speaking their Native languages. It was hoped that in time, the educated Indians would blend in with the white world; in large part, this hope was not realized, and as a whole, Indian and Native children and their families experienced trauma and losses of great magnitude. Horejsi et al. (1992) cited evidence that many Indian children were sexually abused while

attending boarding schools. Few Indian boarding schools exist today, but many believe that the sequelae of Indian children having been placed in the boarding school system continue in the form of family and educational stress (Kleinfeld 1973; Kleinfeld and Bloom 1977; Special Subcommittee on Indian Education, Senate Committee on Labor and Public Welfare 1969). A recent study by Evans-Campbell et al. (2012) found that former attendees of boarding school with two gender identities (two spirit) reported higher rates of current illicit drug use and alcohol use disorder than did individuals who did not attend boarding school. They were significantly more likely to have experienced suicidal thoughts and attempted suicide in their lifetime when compared with nonattendees. Children raised by boarding school attendees were significantly more likely to have a generalized anxiety disorder, symptoms of posttraumatic stress disorder, and suicidal thoughts in their lifetime compared with others who were not raised by attendees of boarding school.

As if boarding Indian children in schools far away from home and for long periods of time were not stressful enough, Indian families were greatly weakened by aggressive out-of-home placements by the child welfare system. It is estimated that in the decades prior to 1975, 25%–30% of Indian and Native children were placed in foster care or adopted out to non-Indian families (Cross et al. 2000). The Indian Child Welfare Act passed by the U.S. Congress in 1978 stopped this practice and has since provided support for the tribe's role in Indian family preservation. The children who experienced this dislocation from their families, communities, and cultures are now adults. Although their needs have not been systematically studied, one can surmise that their mental health needs are complex (Nelson et al. 1996; Roll 1998). It is estimated that 9% of American Indian and Alaska Native children have a serious emotional disturbance, which is two to three times the national average (Nelson et al. 1996; Roll 1998).

Mental and emotional disturbance among American Indian and Alaska Native children and adults is best understood in the context of the multigenerational trauma that Native people have experienced (Duran and Duran 1995). These psychological patterns of colonization may be transmitted through family dynamics even while rapid social change is occurring (Brave Heart and DeBruyn 1998). The trauma dates back to colonial and military subjugation that contributed to the loss of connection to tribal lands, separa-

tion of family members, and disappearance of tribal languages. This trauma is closely associated with high rates of alcohol and drug use, interpersonal violence, and suicide among American Indian and Alaska Native people.

Mental Health Needs and Service System Issues

Focus on American Indians and Alaska Natives has increased in the mental health field during the past decade, but few large-sample epidemiological studies identifying rates of mental disorder have been published. Empirically derived data are still lacking in most areas related to mental health. Even so, existing data suggest that Indian and Native persons across the life span have a disproportionate burden of mental health and substance use problems compared with other Americans. High suicide rates serve as a very strong indicator of need (Allen et al. 2011; Beals et al. 2005a, 2005b; Blum et al. 1992; Gessner 1997; Kertl and Bixler 1991; May 1990; Mock et al. 1996). Overall, suicide rates among all Alaska Native people have increased 500% in the last 60 years, and annual suicide rates between 1990 and 2005 for all Alaska Native cultural groups remained three to six times higher than for the U.S. general population, with the suicide rate of Alaska Natives ages 10–19 four times that of their non-Native cohort (Perkins et al. 2007).

Comorbid conditions, especially alcohol problems and mental health disorders, are of great concern in Indian and Native communities (Beals et al. 2002; Kinzie and Manson 1987; Westermeyer 1982; Westermeyer and Peake 1983; Whitesell et al. 2012; Whittaker 1982). Robin et al. (1997) studied more than 600 members of three large Indian families and found that more than 70% qualified for a lifetime diagnosis of alcohol disorders. Men and women who were alcohol dependent or who were binge drinkers were more likely to have psychiatric disorders than were family members who did not have alcohol use problems. Emerging evidence suggests that Indian adolescents with serious drinking problems are likely to be at risk for mental health problems as well (Beals et al. 2002).

American Indians are the most underserved ethnic group in the United States. Congressional appropriations for the Indian Health Service (IHS), the primary provider of care to American Indian and Alaska Native people, grew by 8% from 1994 to 1998, but after adjustments for inflation and population

growth, the funding had actually declined by 18% (Dixon et al. 2001). In 1998, the IHS established the Level of Need Funded Workgroup, which compared the IHS's per capita spending level with the Federal Employees Health Benefits Program. The study concluded that "the current Indian Health Service budget for personal health care services falls short of parity with other Americans by an estimated 46%" (Level of Need Funded Workgroup 1999). The IHS is able to address only 43% of the known need for mental health services (Dixon et al. 2001). More recently, the IHS in 2011 reported that the recent personal health care expenditures for the IHS user population per person were just \$2,741 in comparison with \$6,909 for the general population. Underfunded IHS budgets affect American Indians' and Alaska Natives' mental health status even more profoundly because less than 10% of the funds allocated for clinical services were allotted for mental health and substance abuse treatment in 2010 (Gone and Trimble 2012). The ratio of mental health service providers to American Indian and Alaska Native children at the beginning of the new millennium was an astonishing 1 to 25,000. The issues that are most salient in examining the mental health service system for Indians and Natives are the need for culturally sensitive providers, greater geographic and economic accessibility of services, outreach to special populations and settings within the community, and intervention in primary care settings (U.S. Department of Health and Human Services 2001). Table 6–1 provides an overview of the questions that may be asked during the first session to start the culturally appropriate assessment of a Native American patient.

Table 6–1. Preparing to see a Native patient

When you know the particular tribe, learn about the tribe's family structure, age and gender roles, and characteristics of typical nonverbal and paralinguistic behavior.

What are the tribe's beliefs about how problems should be resolved?

What is the meaning attributed to illness or disability?

What are the traditional healing practices?

What are the natural support systems?

What are the developmental stress points?

What are the coping strategies?

Applying the DSM-5 Outline for Cultural Formulation

Cultural Identity of the Individual

A case example of a young Indian child who was referred for a mental health evaluation by one of her schoolteachers illustrates the application of the DSM-5 OCF to American Indians and Alaska Natives.

Case 1

Susie, age 10 years, was referred to the school-based health clinic at a public school on a Northern Plains tribal reservation by her fifth-grade teacher. Susie was a midyear transfer student from a much smaller school located in a remote part of the reservation. Her records contained a history of excellent academic and social achievement, but after she had 2 months of sporadic attendance at the new school, a lack of involvement in classroom activities, and episodes of inattention, the teacher requested a psychosocial evaluation of Susie. The teacher highlighted the recent death of Susie's teenage male cousin in a car accident as a possible source of preoccupation and sadness for Susie.

Susie was a member of a Lakota tribe in South Dakota through her mother. She was born in the IHS hospital in the agency town where the tribal seat of governance and various federal Indian offices were located, but she was raised in the mountainous part of the reservation. Susie's father is Ute. He took part in her life during her infancy but stopped doing so after he moved to his home reservation in Utah. Susie's Lakota relatives are numerous and provided active and instrumental support for Susie and her mother, who remained single. Susie was doted on by her extended family, and spiritual leaders believed that she was gifted with a special connection to the spirits. The bilingual education of Susie's Head Start and elementary schools plus her proximity to Lakota-speaking relatives contributed to her moderate level of proficiency in understanding and speaking the Lakota language. Her English skills were very good. Prior to the move to the new school and setting, Susie had liked school very much.

Cultural Reference Group(s)

Often, identifying information at intake will determine whether a new mental health patient has a connection to an Indian tribe or tribes, and if that is the case, it is natural for the clinician to ask about this early in the relationship. From the patient's point of view, he or she expects to be asked about tribal affiliation as one of the beginning topics. Indeed, when one Indian or Native

meets another Indian or Native, one of the first actions of the protocol is to identify where each belongs. “What tribe are you?” is a common question that acknowledges the high value of belonging to a tribal group. The answer can be global (Cheyenne) or specific (Northern Cheyenne).

“Belonging” can be interpreted as formal enrollment as a member, but it can also imply blood affiliation to more than one tribe. Indians and Natives typically are very glad to speak of maternal and paternal Indian ancestry to explain belonging to more than one tribal group. In fact, asking patients to start their sharing about tribal affiliation by speaking about their parents and grandparents may be very comfortable for many. Note, however, that some tribal teachings do not allow a deceased person’s name to be spoken, and thus the patient may use only the general relationship terms.

Mainstream U.S. culture is well acquainted with the terms *full blood*, *half blood*, *half-breed*, and *breed*, in large part through the film and print media. The question “Do you know your blood quantum?” would likely create tension for most Indian and Native patients and thus is best avoided. Many Indians and Natives do know their blood quantum (calculated by knowing one’s Indian ancestors) because it is a criterion for proving Indian ethnicity to tribes, states, and the U.S. federal government. However, many Indians now are ambivalent about the calculation of blood quantum, viewing it as a colonial concept imposed when treaties were signed with the U.S. government. Furthermore, it is thought to breed intragroup oppression in the form of “bloodism,” insinuating that having less Indian blood means that one is less acceptable or less legitimate.

There are approximately 566 federally recognized tribes in the United States (National Congress of American Indians 2013). In addition, several hundred groups are seeking recognition, a process that often takes decades to complete. Because there are hundreds of tribes, the typical clinician cannot be expected to be familiar with every tribal designation. Further complicating the situation, several tribes have recently changed their legal names from those given to them by non-Indians or other tribes to the names for themselves in their tribal languages. Thus, the group of Indians named the Winnebago by the French now prefers to be referenced as the *HoChunk*, and those known as Navajo prefer *Diné*. Alaska Natives did not establish treaties with the U.S. government, but they did develop corporations for groups of villages located in Alaska regions. Communal identity for the Alaska Native is most likely first

with a specific village or region (e.g., Yukon-Tanana region, with the village of Tanana as the hub of several villages) and second with a native corporation (e.g., Tanana Chiefs Conference). Escobar and Vega (2000) recommend using open-ended questions that obtain information about 1) education, 2) wage employment, 3) urbanization, 4) media influence, 5) political participation, 6) religion, 7) daily life, 8) social relations, and 9) perception of past significant events (illnesses, traumas, and tragedies) and their causes.

The CFI (American Psychiatric Association 2013) can be helpful, providing examples of questions to elicit a cultural identity, such as “For you, what are the most important aspects of your background or identity?” (see Appendix 1, “DSM-5 Outline for Cultural Formulation, Cultural Formulation Interview, and Supplementary Modules”). The clinician will then go on to ask how the individual’s cultural identity affects his or her illness. Supplementary module 6, “Cultural Identity,” also offers guidance, providing more examples of questions (34) regarding cultural identity, such as questions 1–4:

1. Where were you born?
2. Where were your parents and grandparents born?
3. How would you describe your family’s national, ethnic, and/or racial background?
4. In terms of your background, how do you usually describe yourself to people outside your community? Sometimes people describe themselves somewhat differently to members of their own community. How do you describe yourself to them?

See Appendix 1 for more examples.

There are other levels of belonging to tribal groups that relate to psychological, spiritual, and social connections. Indians who live or have lived in metropolitan areas are likely to have strong affiliations with Indians from tribes other than their tribes by blood. Also, through intermarriage to non-Indians, many Indians have European, African, Latino, and/or Asian ancestry. Understanding the patient’s sense of belonging to Indian and other racial or ethnic groups is vital to a complete and multifaceted assessment of needs and strengths.

Language

“Is English your first language?” “Do you speak any Native languages?” “How has communicating in English been for you?” These are important questions that address language. Tribal language is central to the modern renaissance and survival of Indian and Native cultures. Each of the five major indigenous language families in North America contains scores of languages within. However, only a few of the oldest generation of Indians and Natives can still understand and speak their native language fluently. The literacy rate in these languages for succeeding generations is extremely low, creating a cultural crisis for most Indian and Native nations. Many believe that spiritual and social ceremonies would be rendered useless or less effective if conducted in a non-Indian language. Others believe that the spiritual and social forces and powers can transcend language, thus allowing for the desired positive outcomes of a ceremony even if a non-Indian language is used. No matter what an Indian or Native believes about this issue, most feel it as a great loss that literacy rates are not high. Nations and villages that have instituted language classes or immersion projects need great support to continue programming because Indian and Native communities are losing native speakers at a much higher rate than they are gaining literate persons. Questions about languages (use, preference, fluency) are also included in CFI supplementary module 6.

Fluent Native language speakers thus are few in number in many Indian communities. Mental health services are usually conducted in English, and it is not likely that a clinician will need translation services. However, proficiency in the use of English is likely to vary greatly across Indian patients—especially when patients are communicating about emotional states and beliefs about wellness and illness. Therefore, having a family member or friend accompany an Indian patient who is not comfortable with his or her English skills is an important choice to offer. Note that trained interpreters with Native language fluency are rarely available within mental health systems, even in Indian communities. When needed, community members are pressed into service. In such cases, following guidelines that protect confidentiality and preserve healthy clinician-patient relationship boundaries is extremely important.

Cultural Factors in Development

Tribes have various ways of addressing developmental stages from the prenatal period to the end of life. A patient who has been an active participant in tribal

life is subject to primary expectations regarding these stages, and there are important transitions and ceremonies for marking them. Any of these aspects can be centrally related to the patient's presentation of wellness and illness. Thus, it is important to ask the patient the following questions: What are valued qualities for a [tribal name] person during this phase of life? What are the necessary accomplishments for the person in this phase of life? What role does the family have in helping the person become what he or she needs to be in this phase of life? What role does the Indian community have in helping the person go through this phase in a good way? What might happen if a person does not do what he or she needs to do during this time? Is there any cultural way to reverse a negative outcome or make it less of a problem?

Involvement in the Culture of Origin

Obviously, if the patient is living within the boundaries of or close to a tribal community, there will be multiple opportunities to participate in tribal-specific and general events for individuals and families. Although these are more difficult to access, many cities have Indian-serving organizations that sponsor events such as Indian dances, craft fairs, health fairs, culture classes, sports programs, meal programs for elders, and social get-togethers. Sometimes a cultural practice from another tribe is available, and it is important to know if participation presents a conflict within the patient's family or circle of friends.

Involvement With the Host Culture

Like other distinct American ethnic groups, Indians and Natives have achieved great familiarity with American culture largely by means of television, movies, and print media. The youths, in particular, have access to cultural perspectives from around the world through educational venues and the Internet. Some individuals lack comfort in non-Indian settings, but many move in and out of mainstream circumstances with ease. Some carry substantial distrust of other cultures—much of this wariness justified by life experiences of prejudice and oppression. Others cultivate understanding of other cultures as a way to take the best of all worlds while continuing to nurture Indian beliefs and practices. Many Indian and Native elders rely on family members to serve as cultural mediators or negotiators. How comfortable are these roles for the patient and his or her family? How does the patient deal with am-

bivalence about non-Indian cultures? How does the patient deal with stereotypes about Indian and Native cultures?

Gender and Sexual Orientation

Mainstream American concepts of gender tend to revolve around being male or female; likewise, sexuality tends to be categorized as “straight” or “gay.” By contrast, at least 168 Native languages have terms for people who are not considered either male or female. Additionally, many Native cultures prescribed important roles within the tribal unit for individuals who were not male or female (Balsam et al. 2004). Most of these roles were eliminated or diminished in the colonization process, and many contemporary Native communities struggle with strong bias against anything other than heterosexual male and female roles. Such bias often prevents a Native person from full access to family and community social support, spiritual coping, and participation in traditional ceremonies and health practices. Native males suffered greatly when cultural change reduced the options for providing for the family and tribal units through warrior and hunter roles. Today, conflicts between sexual/gender identities and ethnic identities can result in great challenges to one’s balance and can compromise the mobilization of personal and cultural resources. In response to limited gender roles and to homophobia, the term *two-spirited* or *two-spirited people* was introduced and has been a helpful self-attribution for many Natives. *Two-spirited* indicates that someone possesses both a male and a female spirit. This term often carries a sense of positive acceptance or even celebration within many Native communities (Tafoya 2003). CFI supplementary module 6 provides some guidance with this as well with questions 29–32:

29. How would you describe your sexual orientation (e.g., heterosexual, gay, lesbian, bisexual, queer, pansexual, asexual)?
30. Do you feel that your sexual orientation has influenced your [PROBLEM] or your health more generally?
31. Do you feel that your sexual orientation influences your ability to get the kind of health care you need for your [PROBLEM]?
32. Do you feel that health care providers have assumptions or attitudes about you or your [PROBLEM] that are related to your sexual orientation? (American Psychiatric Association 2013)

Nonverbal Communication

Native American patients tend to avoid eye contact, to speak only in a low tone of voice, and to have limp handshakes. An approach that may work to show respect for a patient's communication style is to take the lead from the patient; note the patient's behaviors (tone of voice, pace of speech, and degree of eye contact) and match them subtly.

Cultural Conceptualizations of Distress

Case 1 (continued)

Susie, her older teen brother, and her mother moved to the agency town a week before Susie's cousin died in the accident. The transition of the mother enrolling in the tribal college and the children in their respective schools was less smooth than desired because they went back to attend the wake and funeral in their outlying town, rituals that lasted 3 days. Susie did worry very much about her brother's safety because he was a frequent companion of the cousin who passed away. Worry about others is normative in this tribal society, even for young children because the value is to have concern for the family and community network. Because of the move, Susie did not receive as many assurances from her family about her own safety and the safety of her brother as she would have otherwise. Her mother viewed Susie's preoccupation about her brother as normal until she realized that the balance of assurances was not present in the situation.

Further complicating the situation was Susie's report of hearing "spirits." Seeing the spirit of a deceased person during the grieving period of several months after the death is not uncommon in this tribal community. Susie did not experience this, but her teacher thought this was happening and thus encouraged Susie to speak of it. Hearing the singing of spirits was an occasional experience for Susie and was attributed to her special gift. The family believed that speaking about this gift needed to be kept within the privacy of the family because Susie was young and the gift was still emerging. An increase in hearing the singing after her cousin's death was considered by her family's spiritual leaders to be positive and comforting but a matter for the family only.

American Indians and Alaska Natives have implemented effective, holistic diagnostic methods and maintained multiaxial diagnostic knowledge about the human body and human behavior for hundreds of years (Trimble and Thurman 2002). In most Native diagnostic systems, the belief is that this body of knowledge is a gift from the Creator and that it continues to be valu-

able in contemporary thinking. Although many Indian communities have lost much of this indigenous knowledge, elders and culture bearers can provide advice, guidance, and intervention based on Indian-honored perspectives. Some are willing to share across tribal boundaries, and many consider their system a private matter with a patient and his or her family.

Predominant Idioms of Distress and Local Illness Categories

Many scholars, particularly those contributing to ethnographic work, believe that some Indians and Natives express emotional distress and conceive of ill health in ways that do not match the diagnostic nosology of DSM-5 (American Psychiatric Association 2013). Idioms of distress and local illness categories in this population have been described (Manson 1994; Manson et al. 1985; Nelson and Manson 2000; Trimble et al. 1984). Frequently cited examples are *ghost sickness* or *windigo* (a preoccupation with death and the deceased, identified in Northern Algonquian peoples [Marano 1985]), *pibloktoq* or *Arctic hysteria* (abrupt episodes of extreme excitement), and *wicinko* (a Siouan-language term referring to a form of cultural “time-out,” used for coping when the patient believes family members are placing too much of a burden on him or her).

Many of the indigenous illness and wellness categories are related to spiritual conditions. Jilek-Aall (1976) reminds us that the question of how spiritual matters may or may not affect the patient’s current situation has to be raised at a time when the patient has confidence in the therapeutic process. One prudent approach would be to ask the patient to tell his or her life story and let him or her state what he or she believes is appropriate. When the patient brings it up, it is important to be nonjudgmental about the belief system and share observations of the positive outcomes that many people have had by embracing and practicing traditional ways.

Spirituality, Religion, and Moral Traditions

Assessing the patient’s spiritual beliefs can be helpful, as seen in Hatala’s (2008) work in Canada with aboriginals, which showed that spirituality had positive effects on health and healing. In addition, Kulis et al. (2012) suggested that spirituality and religion can be protective factors for substance abuse in urban youths. Hodge and Limb (2010) suggested the use of five assessment tools: spiritual history, spiritual life map, spiritual genogram, spiri-

tual ecomap, and spiritual ecogram. The spiritual history has two sets of questions, one narrative and one anthropological, whereas the spiritual life map is a diagram of the patient's relationship with the Creator. The spiritual genogram is thought to be helpful to bring in the influence of other generations. The spiritual ecomap starts with the patient's family system in the center of the page, and other spiritual systems are drawn in around it. Finally, the spiritual ecogram is a combination of a genogram and an ecomap. The authors suggest that any number of the tools may be used in an assessment as long as it is effective for the patient.

CFI supplementary module 5, "Spirituality, Religion, and Moral Traditions," has a series of questions to help begin the conversation about spirituality, and the first four are particularly useful.

1. Do you identify with any particular spiritual, religious or moral tradition? Can you tell me more about that?
2. Do you belong to a congregation or community associated with that tradition?
3. What are the spiritual, religious or moral tradition backgrounds of your family members?
4. Sometimes people participate in several traditions. Are there any other spiritual, religious or moral traditions that you identify with or take part in?

The understanding of mainstream diagnostic classification is very limited in Indian and Native communities, but most Indians and Natives have been exposed to the same layperson's terms for the common disorders in actions, cognitions, and emotions as other English-speaking citizens of the United States. Many Indians and Natives today associate stigma with many of these disorders, even though there might have been less stigma or none in times prior to modern diagnosis from Western medicine. Understandably, the process of labeling is highly suspect for many Indians and Natives.

Meaning and Severity of Symptoms in Relation to Cultural Norms

It may be an Indian or Native cultural norm that physical symptoms and medical diagnoses such as arthritis are easier to talk about than emotional pain or distress, but little empirical research is available on this. Somervell et al. (1992–1993) analyzed responses to the Center for Epidemiologic Studies De-

pression Scale. Somatic complaints and emotional distress were not well differentiated from each other in the adult sample from a Northwest Coast tribe. It is important to ask about the relative importance of symptoms to the patient because cultural norms may not place the same degree of emphasis on symptoms that they receive in the DSM-5 diagnostic system. An example of an Indian person who appears depressed and without energy illustrates this. The person may not actually be in a hopeless state and may believe that solutions will emerge in their own time. This state of expectation may be misinterpreted through a Western perspective as passivity and lack of initiative (Blue and Blue 1983).

Perceived Causes and Explanatory Models

Indian and Native beliefs about why and how illness develops differ widely across North America; spiritual elements are common in explanatory models. This is also true of why and how wellness is achieved and maintained. The range of explanations includes 1) a wrong act against another person, part of creation, or the Creator; 2) not performing an act when it is warranted; 3) being the victim of spiritual hexing perpetrated by another person; 4) being out of balance or harmony; and 5) being influenced or affected by spiritual entities. A good way to assess for this is to ask the following: “Families and communities have ideas about why and how experiences such as the one you are describing come about. If a trusted elder from your community were here, what would he or she say was the reason you are experiencing this?”

CFI supplementary module 1, “Explanatory Model,” offers some guidance for questions regarding the patient’s health beliefs in questions 1–14 (see Appendix 1, pp. 494–496). A simple approach would be to pause after the history of present illness is obtained and ask the patient what he or she thinks is the problem, which is illustrated in Video 5–1. (See Case 1 in Chapter 5, “Issues in the Assessment and Treatment of Latino Patients,” for the case background.) The interviewer asks many of the questions in supplementary module 1, including whether the patient had ever heard of the illness before.



Video Illustration 5–1: Cultural concepts of distress—*ataque de nervios* (3:06)

Help-Seeking Experiences and Plans

One in five Indians and Natives reports having access to the health services provided by the IHS to those living on or near reservations and trust lands (Brown et al. 2000). Because of chronic underfunding of the agency, mental health services, if present at all, are often extremely limited. Indians and Natives are largely uninsured or underinsured and thus do not have access to mainstream mental health services in the public and private sectors. Often there is great mistrust of formal health care systems, and it is important to learn the patient's history with regard to available mental health services, whether through the IHS, a tribally administered health department, Medicaid, Medicare, or another system.

Many contemporary Indian and Native communities are fortunate enough to have long-standing traditional healing and support for personal and family development. By and large, family leaders arrange access to this healing. The medicinal use of plants and roots is common in some Indian communities. Several targeted studies suggest that American Indians and Alaska Natives use alternative therapies at rates that are equal to or greater than the rates for whites (Buchwald et al. 2000; Gurley et al. 2001; Kim and Kwok 1998; Marbella et al. 1998). In these studies, Native healing generally was used in addition to mainstream health services, not as a substitute for them.

Care must be taken not to be intrusive in questioning about traditional healing. The clinician could say, "Seeking traditional healing may be a private matter for you and your family, so I will understand if you choose not to share details about it. It will be helpful for me to at least know the different ways you and your family are getting help for your situation." Indians and Natives who do not have access to traditional healing may be open to the clinician's help in identifying resources. In rare cases, there may be a respectful way to interface the traditional Native resources with the conventional interventions of Western medicine. The situations in which such collaboration has been successful have usually emerged after a lengthy period of trust building between practitioners, in which roles, information sharing, confidentiality, compensation, and other key issues were clearly delineated (Manson 1994).

Conventional health systems have successfully integrated some long-held tribal traditions, to the benefit of Indian and Native consumers. Examples are the use of adults in the extended family as nonparental disciplinarians in a

Northwest tribe's group home for youths in foster care (Shore and Nicholls 1975), the use of the Plains Indian medicine wheel as a tool for self-analysis (Robbins 1994), and the use of the "talking circle" as a way to process psychological, social, and spiritual issues in a group format. Some health programs have sweat lodges for use by Indian and Native patients. The ceremony itself can be conducted by a health staff person or a community member, and in either case, the ceremony leader or "water pourer" is recognized by the Indian community as prepared to help others in the sweat lodge.

Psychosocial Stressors and Cultural Features of Vulnerability and Resilience

Case 1 (*continued*)

Susie's mother moved the family in with relatives who lived in an old Bureau of Indian Affairs house in the agency town. There were six adults and four children in a two-bedroom house. Overcrowding in substandard housing is very common on this reservation. Susie's mother was excited about being a college student for the first time, but awareness of the time that had passed between high school and her associate of arts college program created much anxiety for her. Susie had been coddled in her previous household, but there were greater expectations in the new household for Susie to complete tasks around the home. Susie's mother did not have much time to prepare her for these new expectations, and tensions developed between Susie and other household members when Susie did not perform as expected.

Social Stressors

Indian communities are marked by great economic disadvantage; unemployment, underemployment, and housing shortages, among others, are indicators of widespread stress. From 1997 to 1999, about 26% of Indians and Natives lived in poverty, compared with 13% for the United States as a whole and 8% for white Americans (U.S. Census Bureau 1999). Asking about daily life in the patient's community provides the patient an opportunity to describe stressors common to many.

Social Supports

Most Indian communities, both rural and urban, hold expectations based on cultural beliefs that the family will provide instrumental and emotional sup-

port for its members. The *tiospaye*, a Lakota expression of traditional lifestyle based on extended family, shared responsibility, and reciprocity (Mohatt and Blue 1982), is being revitalized in many northern Plains Indian communities. Contemporary stresses on Indian families often work against smooth provision of support. When the expectations do not match the actual behaviors, tensions can develop among family members, leading to many possible negative emotions and behaviors.

Intergenerational Relationships

The value of a strong extended family whose members from each generation actively support one another is very robust in American Indian and Alaska Natives. Children are considered sacred gifts to be nurtured and protected. Children are also considered teachers within the family and tribal nation. Similarly, elders are carriers of valuable indigenous knowledge and wisdom. Each phase of life holds tasks and blessings for the individual that will benefit the family and tribe. These teachings about intergenerational harmony and support are being articulated more clearly now as tribal nations revitalize the ways culture is celebrated and practiced. Families that have been challenged over the last three to four generations by the negative effects of boarding schools, out-of-home placements of the children, substance abuse, extreme poverty, and other devastating outcomes of colonialism are not in tune with these teachings about the strengths of the extended family. Thus, conflicts between generations often present concern at behavioral health clinics. Family-centered approaches are considered to be promising and consistent with the values of most Indian and Native communities.

Levels of Functioning and Disability

Culture very much defines the parameters of “normal” functioning and the assessment of abilities. In Indian cultures, where belonging to and contributing to the larger group are highly valued, a child with severe developmental disabilities might be described as functioning highly because he brings wood into the house for the daily fire. In this case, the contribution to the household, however simple, overshadows what might be called disabilities by other standards.

CFI supplementary module 3, “Social Network,” helps to outline how to assess a patient’s support system. The 15 questions ask patients to talk about

whom they talk to about their problems and who gives them advice or helps with their treatment (see Appendix 1, pp. 497–498).

Cultural Features of the Relationship Between the Individual and the Clinician

Case 1 (*continued*)

The clinician who evaluated Susie for poor school performance was a new behavioral health consultant to that public school's new medical clinic, which targeted diabetes prevention in the school population. She had not served Indian children before but was able to connect with Susie through drawing. Susie did not want to talk about her cousin and did not bring up the singing; however, she did say that she missed her family from her former home. The clinician sought the guidance of the school's home-school coordinator, a Lakota woman who knew many families on the reservation. The home-school coordinator believed that Susie's extended family had many resources to give, and she urged the clinician to ask Susie to have other family members participate in the evaluation if she wished. Two older aunts came with Susie's mother for the intake interview at the new school. They listened carefully to the observations of the school staff and provided background information when Susie's mother indicated that she wanted their input. They also made it clear what issues would be addressed by the family in their ceremonies. Together, they came up with ways the school staff could support Susie and her mother through the challenging circumstances.

Just as the clinician has questions about the patient and his or her situation, the patient has questions and expectations about the provider and about the processes called diagnosis, assessment, and therapeutic intervention. A focus on counselor characteristics and considerations is prominent in the publications by counselors, clinicians, and scholars regarding mental health interventions with Native American Indians (Trimble and Thurman 2002).

Indians and Natives have ideas about—if not experience with—providers of mental health services from a Western health care system and also about helpers from indigenous healing systems (Tables 6–2 and 6–3). The latter group are variously called *medicine men* and *medicine women*, *shamans*, *spiritual leaders*, and *healers*, among other terms specific to certain tribes (e.g., the *hand trembler* of the Diné/Navajo). The non-Indian clinician may have difficulty with the belief systems associated with indigenous ceremonies and

Table 6–2. Native American patient's expectations of a non-Native healer

I expect the healer not to know much about Indians in general, let alone the history of my tribe, its traditional beliefs and values, current tribal organization, and its problems and resources.

I expect that the healer will not value healing rituals.

I expect the healer to consider only the deficits and to ignore the strengths of myself, my family, and my community.

I expect that the healer will understand reluctance to talk about my strengths and resources because it could be interpreted as boasting.

I expect that the healer will not understand how hard it is to honor Native traditions and survive in the host culture.

I expect to question the trustworthiness of the healer.

I expect to present a concrete problem before I talk about other kinds of problems.

I expect not to trust the mental health system because I believe it is likely to be patronizing (based on experiences with the Bureau of Indian Affairs and Indian Health Service) and nonsupportive of self-determination.

I expect that the healer will not talk about the mutual responsibilities of the healer and myself.

herbal medicines. However, because many Indians and Natives hold great respect for indigenous healing ways, the non-Native clinician is exhorted to suspend disbelief and to listen to and hear whatever the Indian patient shares (Trimble and Thurman 2002).

Although it is natural to focus on the differences in theory, belief, and approach between Western and indigenous healers, Torrey (1986) has described commonalities. Indian and Native healers often exemplify empathy, genuineness, availability, respect, warmth, congruence, and concreteness; correspondingly, most Western mental health theories and styles predicate their interventions on a basic therapeutic relationship in which the provider communicates these characteristics to the patient.

Reimer (1999) asked Inupiat villagers in Alaska to state the characteristics they found desirable in a healer. Their replies (described in Table 6–4) included expectations for community, cultural, and spiritual involvement, as

Table 6–3. Native American patient's expectations of an indigenous healer

I expect that the healer/diagnostician will identify my problems without prying too deeply into my personal life or asking many intimate questions.
I expect that family members will be involved.
I expect that improvement will occur quickly.
I expect the healer to “take charge” and solve the problem. I will be hopeful, but the healer is the active one.
I expect the healer to consider all of myself: physical, mental, emotional, spiritual, and interpersonal domains.
I expect to be understood within the context of my relationship to Nature.
I expect that my individual hurt is also a community hurt.
I expect that “harmony and balance” will be considered important in understanding my situation.
I expect that the healer will understand how breaking a taboo or ignoring a tradition can result in my circumstance.

well as attributes and behavior conventionally expected to be a major part of the clinical encounter. If domains other than mental health are the purview of the respected healer, it stands to reason that Indians and Natives might meet a Western-trained provider of mental health services and expect assistance with medical concerns, spirituality, financial issues, or the problems of persons important to the patient (Helms and Cook 1999).

Empirical research, case studies, and clinical experience also identify the following clinician characteristics associated with effective therapeutic relationships: the clinician 1) is trustworthy (LaFromboise and Dixon 1981), 2) uses self-disclosure to show warmth and genuineness (Lockhart 1981), 3) provides practical advice and is flexible about the location of service (LaFromboise et al. 1980), and 4) dresses and presents himself or herself in a way that reflects the community's beliefs about leadership and authority figures (Littrell and Littrell 1983) (see Table 6–5).

Some researchers say that the best match for an Indian or Native patient is an Indian or Native provider (Darou 1987; Uhlemann et al. 1988). This seems

Table 6–4. Native American patients' desired characteristics of therapists

A therapist should be

Virtuous, kind, respectful, trustworthy, friendly, gentle, loving, clean, giving, helpful, not a gossip, and not one who wallows in self-pity

Strong physically, mentally, spiritually, personally, socially, and emotionally

A good therapist

Is respected because of his or her knowledge, disciplined in thought and action, wise and understanding, and willing to share knowledge by teaching and serving as an inspiration

Is substance free

Works well with others by becoming familiar with people in the community

Has good communication skills, achieved by taking time to talk, visit, and listen

Knows and follows the culture

Has faith and a strong relationship with the Creator

Source. Adapted from Reimer 1999.

to be particularly true of patients who are involved with their Indian/Native heritage (Johnson and Lashley 1989). In a study by Bennett and BigFoot-Sipes (1991), Indians said that being matched with counselors whose attitudes and beliefs were similar to theirs was more important than shared ethnicity. Dinges et al. (1981) acknowledged that ethnic match might support rapport building but asserted that perceived effectiveness (e.g., warmth, genuineness, respect, and empathy) is more likely than ethnic match to sustain the therapeutic relationship. Herring (1999) pointed out that because very few Indians and Natives are mental health professionals, non-Indians will serve Indian and Native patients for quite a long time to come. Thus, although shared ethnicity is important, all clinicians need to be knowledgeable and skilled in assessing and treating Indians and Natives. Using a cultural consultant, clinician, or community member who is familiar with the patient's reference group is helpful in determining normative and nonnormative behavior and symptoms. In addition, there are specific techniques that are likely to be helpful in engaging the patient (Table 6–6).

Table 6–5. Developing trust between Indian and Native patients and their therapists

Therapists who gained their patient's trust

Were attentive and responsive to the patient

Gave structure and direction to the interview

Showed respect for the patient's cultural identity

Used eye contact similar to that of the patient

Sat erect in their chair

Avoided references to time until the end of the session

Source. Adapted from LaFromboise and Dixon 1981.

CFI supplementary module 8, “Patient-Clinician Relationship,” offers five questions for the patient and seven for the clinician after the patient has left the room. Questions 1–4 are about getting a history of the patient's relationships with therapists, and question 5 addresses whether any differences between the clinician and the patient will affect their working relationship (see Appendix 1, pp. 507–509).

Overall Cultural Assessment

Case 1 (*continued*)

Susie and her mother are clearly identified with their clan and greater tribal community. At the time of referral for behavioral health services, the family had been separated from their extended family for a brief period and had not yet developed ties with their new community and its resources. Clearly, it was wise to mobilize the extended family in support of Susie and her mother during the assessment of Susie's needs. The home-school coordinator was able to enlist the help of the family because of her wide knowledge of the several reservation communities and the ease with which family elders could travel the distance to the agency town and participate in sessions at the school. The consequence of this collaboration with the family's natural helping system was greater understanding of the severity of the illness experience (academic problems and worry) from the cultural point of view and clear expectations for appropriate intervention at the school.

Table 6–6. Building effective therapeutic relationships between Indian and Native patients and therapists

Explain to the patient that you will have plenty of time to get to know each other before discussing any concerns the patient may have.

Communicate that there are no demands to behave a certain way or talk a certain amount.

Avoid lengthy intake forms or questionnaires.

Accept the presence of a friend or family member.

Ensure that the atmosphere is relaxed, casual, and nonthreatening.

Use an informal, conversational verbal style.

Talk about practical issues of daily life before talking about intimate issues.

Use self-disclosure as a way to prompt self-disclosure on the part of the patient.

Avoid direct questioning for a while.

Communicate warmth, caring, genuineness, and respect.

The task of synthesizing the information gleaned from assessment that contains the cultural context of the Indian patient is one that will likely result in a formulation that is balanced with the identification of problem areas and strengths. A key in the assessment process is to identify the Indian or Native's level of affiliation with non-Indian and Indian cultures. Another is to learn about the historical issues that affect the individual, family, and community. Several recommendations for establishing a "culturally affirmative environment" (Herring 1999) for Indians and Natives have been identified. These suggestions (detailed in Table 6–7) call for candor, flexibility, patience, openness to family involvement, development of trust, respect for culture, and maintenance of confidentiality (Herring 1999).

Finally, certain therapeutic approaches may be more effective, such as a more direct, present-focused therapy that prioritizes problem-solving techniques. One should avoid techniques such as explorative psychotherapy, promotion of catharsis, and a permissive approach.

Table 6–7. Suggestions for working with Native American patients

Therapists sensitive to Native American patients should

- Openly address the issue of dissimilar ethnic relationships rather than pretending that there are no differences
- Schedule appointments with gaps between appointments to allow for flexibility in ending the session rather than having rigid 50-minute sessions
- Consider the extended family as part of the patient's community and allow them to participate in the session
- Allow time to build trust to develop before focusing on problems
- Recognize the uses and value of silence
- Act in ways that show honor and respect for the patient's culture
- Respect the patient's need for the highest level of confidentiality

Source. Adapted from Herring 1999.

Conclusion

As time goes on, American Indian and Alaska Native populations will increasingly become consumers in health systems that are not yet prepared for them. The scenario that began this chapter can become a reality if certain developments occur to address the many knowledge and skill gaps that exist in mental health services for Indian and Native people. Clinical training programs can include curricula and access to clinical sites specific to this population. Researchers and clinicians can carefully document interventions that are effective not only globally with Indians and Natives but also with specific tribes. Health systems can institute in-service training on a regular basis to providers, can hire Indian or Native providers whenever possible, and can develop linkages with the Indian community or communities within the region.

As Indian and Native communities continue on their journey of revitalization, they are becoming more active in designing health systems that work for them. There is an increased awareness that behavioral health services are vital to bettering the overall health of Indians and Natives. In *Mental Health: Culture, Race, and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General* (U.S. Department of Health and Human Services 2001), the

take-home message is that “culture counts.” The opportunity is ripe for establishing partnerships between the service provider sector and the Indian community. The efforts of each of us can count significantly in this important venture.

References

- Allen J, Levintova M, Mohatt G: Suicide and alcohol-related disorders in the U.S. Arctic: boosting research to address a primary determinant of health disparities. *Int J Circumpolar Health* 70(5):473–487, 2011
- American Psychiatric Association: Appendix I: Outline for cultural formulation and glossary of culture-bound syndromes, in *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000, pp 897–903
- American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition. Washington, DC, American Psychiatric Association, 2013
- Balsam KF, Huang B, Fieland KC, et al: Culture, trauma, and wellness: a comparison of heterosexual and lesbian, gay, bisexual, and two-spirit Native Americans. *Cultur Divers Ethnic Minor Psychol* 10(3):287–301, 2004
- Beals J, Novins DK, Mitchell CM, et al: Comorbidity between alcohol abuse/dependence and psychiatric disorders: prevalence, treatment implications, and new directions for research among American Indian populations, in *Alcohol Use Among American Indians and Alaska Natives: Multiple Perspectives on a Complex Problem* (NIAAA Monograph No 37). Edited by Mail PD, Heurtin-Roberts S, Martin SE, et al. Bethesda, MD, National Institute on Alcohol Abuse and Alcoholism, 2002, pp 317–410
- Beals J, Manson SM, Whitesell NR, et al: Prevalence of DSM-IV disorders and attendant help-seeking in 2 American Indian reservation populations. *Arch Gen Psychiatry* 62(1):99–108, 2005a
- Beals J, Manson SM, Whitesell NR, et al: Prevalence of major depressive episode in two American Indian reservation populations: unexpected findings with a structured interview. *Am J Psychiatry* 162(9):1713–1722, 2005b
- Bennett S, BigFoot-Sipes D: American Indian and white college students’ preferences for counselor characteristics. *J Couns Psychol* 38(4):440–445, 1991
- Blue A, Blue M: The strain of stress. *White Cloud Journal of American Indian-Alaska Native Mental Health* 3(1):15–22, 1983



- Blum RW, Harmon B, Harris L, et al: American Indian—Alaska Native youth health. *JAMA* 267(12):1637–1644, 1992
- Brave Heart MY, DeBruyn LM: The American Indian holocaust: healing historical unresolved grief. *Am Indian Alsk Native Ment Health Res* 5:56–78, 1998
- Brown ER, Ojeda VD, Wyn R, et al: Racial and Ethnic Disparities in Access to Health Insurance and Health Care. Los Angeles, CA, UCLA Center for Health Policy Research and the Henry J Kaiser Family Foundation, 2000
- Buchwald DS, Beals J, Manson SM: Use of traditional health practices among Native Americans in a primary care setting. *Med Care* 38(12):1191–1199, 2000
- Cross TA, Earle KA, Simmons D: Child abuse and neglect in Indian country: policy issues. *Fam Soc* 81:49–58, 2000
- Darou WG: Counseling and the northern Native. *Can J Counsell* 32:33–41, 1987
- Dinges N, Trimble JE, Manson S, et al: Counseling and psychotherapy with American Indians and Alaska Natives, in *Cross-Cultural Counseling and Psychotherapy: Foundations, Evaluation, and Cultural Considerations*. Edited by Marsella AJ, Pedersen PB. Elmsford, NY, Pergamon, 1981, pp 243–276
- Dixon M, Mather DT, Shelton BL, et al: Economic and organizational changes in health care systems, in *Promises to Keep: Public Health Policy for American Indians and Alaska Natives in the 21st Century*. Edited by Dixon M, Roubideaux Y. Washington, DC, American Public Health Association, 2001, pp 89–134
- Duran E, Duran B: *Native American Postcolonial Psychology*. Albany, State University of New York Press, 1995
- Escobar JI, Vega WA: Mental health and immigration's AAAs: where are we and where do we go from here? *J Nerv Ment Dis* 188(11):736–740, 2000
- Evans-Campbell T, Walters KL, Pearson CR, et al: Indian boarding school experience, substance use, and mental health among urban two-spirit American Indian/Alaska Natives. *Am J Drug Alcohol Abuse* 38(5):421–427, 2012
- Fleming W: *The Complete Idiot's Guide to Native American History*. Indianapolis, IN, Alpha Books, 2003
- Gessner BD: Temporal trends and geographic patterns of teen suicide in Alaska, 1979–1993. *Suicide Life Threat Behav* 27(3):264–273, 1997
- Gone JP, Alcántara C: Identifying effective mental health interventions for American Indians and Alaska Natives: a review of the literature. *Cultur Divers Ethnic Minor Psychol* 13(4):356–363, 2007
- Gone JP, Trimble JE: American Indian and Alaska Native mental health: diverse perspectives on enduring disparities. *Annu Rev Clin Psychol* 8:131–160, 2012
- Gurley D, Novins DK, Jones MC, et al: Comparative use of biomedical services and traditional healing options by American Indian veterans. *Psychiatr Serv* 52(1):68–74, 2001

- Hatala AR: Spirituality and Aboriginal mental health: an examination of the relationship between Aboriginal spirituality and mental health. *Adv Mind Body Med* 23(1):6–12, 2008
- Helms JE, Cook DA: *Using Race and Culture in Counseling and Psychotherapy: Theory and Process*. Boston, MA, Allyn & Bacon, 1999
- Herring RD: *Counseling With Native American Indians and Alaska Natives: Strategies for Helping Professionals*. Thousand Oaks, CA, Sage, 1999
- Hodge DR, Limb GE: A Native American perspective on spiritual assessment: the strengths and limitations of a complementary set of assessment tools. *Health Soc Work* 35(2):121–131, 2010
- Horejsi C, Craig BHR, Pablo J: Reactions by Native American parents to child protection agencies: cultural and community factors. *Child Welfare* 71(4):329–342, 1992
- Jilek-Aall L: The Western psychiatrist and his non-Western clientele: transcultural experiences of relevance to psychotherapy with Canadian Indian patients. *Can Psychiatr Assoc J* 21(6):353–359, 1976
- Johnson M, Lashley K: Influence of Native Americans' cultural commitment on preferences for counselor ethnicity and expectations about counseling. *J Multicult Couns Devel* 17(3):115–122, 1989
- Ketttl PA, Bixler EO: Suicide in Alaska Natives, 1979–1984. *Psychiatry* 54(1):55–63, 1991
- Kim C, Kwok YS: Navajo use of native healers. *Arch Intern Med* 158(20):2245–2249, 1998
- Kinzie JD, Manson SM: The use of self-rating scales in cross-cultural psychiatry. *Hosp Community Psychiatry* 38(2):190–196, 1987
- Kleinfeld J: *A Long Way From Home: Effects of Public High Schools on Village Children Away From Home*. Fairbanks, AK, Center for Northern Educational Research and Institute of Social, Economic, and Government Research, 1973
- Kleinfeld J, Bloom J: Boarding schools: effects on the mental health of Eskimo adolescents. *Am J Psychiatry* 134(4):411–417, 1977
- Kulis S, Hodge DR, Ayers SL, et al: Spirituality and religion: intertwined protective factors for substance use among urban American Indian youth. *Am J Drug Alcohol Abuse* 38(5):444–449, 2012
- LaFromboise T, Dixon D: American Indian perceptions of trustworthiness in a counseling interview. *J Couns Psychol* 28(2):135–139, 1981
- LaFromboise T, Dauphinais P, Rowe W: Indian students' perceptions of positive helper attributes. *Journal of American Indian Education* 19:11–16, 1980
- Level of Need Funded Workgroup: *Level of Need Funded Study (LNF Workgroup Report II)*. Rockville, MD, Indian Health Service, 1999

- Littrell MA, Littrell JM: Counselor dress cues: evaluations by American Indians and Caucasians. *J Cross Cult Psychol* 14(1):109–121, 1983
- Lockhart B: Historic distrust and the counseling of American Indians and Alaskan Natives. *White Cloud Journal of American Indian-Alaska Native Mental Health* 2(3):31–43, 1981
- Manson SM: Culture and depression: discovering variations in the experience of illness, in *Psychology and Culture*. Edited by Lonner WJ, Malpass RS. Needham, MA, Allyn & Bacon, 1994, pp 285–290
- Manson SM, Shore JH, Bloom JD: The depressive experience in American Indian communities: a challenge for psychiatric theory and diagnosis, in *Culture and Depression*. Edited by Kleinman A, Good B. Berkeley, University of California Press, 1985, pp 331–368
- Marano L: Windigo psychosis: the anatomy of an emic-etic confusion, in *The Culture-Bound Syndromes: Folk Illnesses of Psychiatric and Anthropological Interest*. Edited by Simons RC, Hughes CC. Boston, MA, D Reidel, 1985, pp 411–448
- Marbella AM, Harris MC, Diehr S, et al: Use of Native American healers among Native American patients in an urban Native American health center. *Arch Fam Med* 7(2):182–185, 1998
- May PA: A bibliography on suicide and suicide attempts among American Indians and Alaska Natives. *Omega* 21(3):199–214, 1990
- Mock CN, Grossman DC, Mulder D, et al: Health care utilization as a marker for suicidal behavior on an American Indian reservation. *J Gen Intern Med* 11(9):519–524, 1996
- Mohatt G, Blue AW: Primary prevention as it relates to traditionality and empirical measures of social deviance, in *New Directions in Prevention Among American Indian and Alaska Native Communities*. Edited by Manson SM. Portland, Oregon Health Sciences University, 1982, pp 91–116
- National Congress of American Indians: Introduction to Tribal Governments. Washington, DC, National Congress of American Indians, 2013. Available at: <http://www.ncai.org/about-tribes>. Accessed February 1, 2013.
- Nelson K, Cross T, Landsman M, et al: Native American families and child neglect. *Child Youth Serv Rev* 18(6):505–522, 1996
- Nelson S, Manson SM: Mental health and mental disorder, in *The Health of American Indians and Alaska Natives*. Edited by Rhoades ER. Baltimore, MD, Johns Hopkins University Press, 2000, pp 311–327
- Norris T, Vines PL, Hoeffel M: The American Indian and Alaska Native Population: 2010, in *2010 Census Briefs (2010BR-10)*. Washington, DC, U.S. Census Bureau, January 2010. Available at: <http://www.census.gov/prod/cen2010/briefs/c2010br-10.pdf>. Accessed February 1, 2013.

- Perkins R, Sanddal T, Sanddal N, et al: Alaska Suicide Follow-back Study Final Report. Juneau, Alaska Department of Health and Social Services, 2007. Available at: http://dhss.alaska.gov/SuicidePrevention/Documents/pdfs_sspc/sspcfollwback2-07.pdf. Accessed April 28, 2014.
- Reimer CS: Counseling the Inupiat Eskimo. Westport, CT, Greenwood, 1999
- Robbins ML: Native American perspective, in *Managing Multiculturalism in Substance Abuse Services*. Edited by Gordon JU. Thousand Oaks, CA, Sage, 1994, pp 148–176
- Robin RW, Chester B, Rasmussen JK, et al: Prevalence, characteristics, and impact of childhood sexual abuse in a Southwestern American Indian tribe. *Child Abuse Negl* 21(8):769–787, 1997
- Roll S: Cross-cultural considerations in custody and parenting plans. *Child Adolesc Psychiatr Clin N Am* 7(2):445–454, 1998
- Rural Policy Research Institute: Rural by the numbers: information about rural America. Columbia, MO, Rural Policy Research Institute, 1997
- Shore JH, Nicholls WM: Indian children and tribal group homes: new interpretations of the Whipper Man. *Am J Psychiatry* 132(4):454–456, 1975
- Somervell PD, Beals J, Kinzie JD, et al: Use of the CES-D in an American Indian village. *Cult Med Psychiatry* 16(4):503–517, 1992–1993
- Special Subcommittee on Indian Education, Senate Committee on Labor and Public Welfare: Indian Education: A National Tragedy, a National Challenge (Senate Report No 91–501). Washington, DC, U.S. Senate, 1969
- Tafoya T: Native gay and lesbian issues: the two-spirited, in *Psychological Perspectives on Lesbian, Gay, and Bisexual Experiences*, 2nd Edition. Edited by Garnets LD, Kimmel DC. New York, Columbia University Press, 2003, pp 401–409
- Thornton R: American Indian Holocaust and Survival: A Population History Since 1492. Norman, University of Oklahoma Press, 1987
- Torrey EF: *Witch Doctors and Psychiatrists: The Common Roots of Psychotherapy and Its Future*. New York, Harper & Row, 1986
- Trimble J, Thurman PJ: Ethnocultural considerations and strategies for providing counseling services to Native American Indians, in *Counseling Across Cultures*, 5th Edition. Edited by Pedersen PB, Draguns JG, Lonner WJ, et al. Thousand Oaks, CA, Sage, 2002, pp 53–91
- Trimble JE, Manson SM, Dinges NG, et al: Towards an understanding of American Indian concepts of mental health: some reflections and directions, in *Mental Health Services: The Cross/Cultural Context*. Edited by Pedersen P, Sartorius N, Marsala A. Beverly Hills, CA, Sage, 1984, pp 199–220
- Uhlemann M, Lee D, France H: Counsellor ethnic differences and perceived counseling effectiveness. *Int J Adv Couns* 11:247–253, 1988

- U.S. Census Bureau: The American Indian and Alaska Native Population: 2010. Washington, DC, U.S. Census Bureau, 2010. Available at: <http://www.census.gov/prod/cen2010/briefs/c2010br-10.pdf>. Accessed April 26, 2014.
- U.S. Census Bureau: Statistical Abstract of the United States: The National Data Book. Washington, DC, U.S. Census Bureau, 1999
- U.S. Department of Health and Human Services: Mental Health: Culture, Race, and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD, U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General, 2001. Available at: <http://www.ncbi.nlm.nih.gov/books/NBK44243/?term=supplement%20to%20mental%20health>. Accessed April 26, 2014.
- Waldman C: Atlas of the North American Indian. New York, Facts On File, 1985
- Westermeyer J: Alcoholism and services for ethnic populations, in *Encyclopedic Handbook of Alcoholism*. Edited by Pattison E, Kaufman E. New York, Gardner Press, 1982, pp 709–717
- Westermeyer J, Peake E: A ten-year follow-up of alcoholic Native Americans in Minnesota. *Am J Psychiatry* 140(2):189–194, 1983
- Whitesell NR, Beals J, Crow CB, et al: Epidemiology and etiology of substance use among American Indians and Alaska Natives: risk, protection, and implications for prevention. *Am J Drug Alcohol Abuse* 38(5):376–382, 2012
- Whittaker JO: Alcohol and the Standing Rock Sioux Tribe: a twenty-year follow-up study. *J Stud Alcohol* 43(3):191–200, 1982

This page intentionally left blank

Cultural Issues in Women's Mental Health

Lisa Andermann, M.Phil., M.D., FRCPC

Kenneth P. Fung, M.D., M.Sc., FRCPC

It is of key importance that a clinical manual of cultural psychiatry include a chapter on women. As is emphasized throughout this volume with the DSM-5 Outline for Cultural Formulation (OCF) format, one's cultural identity focuses on not only ethnicity, race, and migration but also both biologically determined sex and culturally determined gender roles (American Psychiatric Association 2013). Tseng (2003) writes that "even though the Earth's population is composed half of men and half of women, differences in treatment between men and women have perhaps existed from the beginning of the history of humankind" (p. 382). Of course, if women also belong to a socially marginalized group, they may be subject to double discrimination. Along with biological differences, experiences of unequal treatment, sociocultural discrimination, sexual harassment, and gender-based violence are all im-

portant factors in the social determinants of women's mental health (Andermann 2006, 2010; Blehar 2006; Vigod and Stewart 2009; World Health Organization 2000, 2009).

Women's mental health has come into its own over the years as a subspecialty in psychiatry. In this chapter, we take a life cycle approach to explore some of the cultural issues related to women's mental health across the life span: from birth through childhood and adolescence, adulthood and child-rearing years, and aging. We trace some of the important historical developments in the women's movement in North America and internationally and how these have shaped the field of women's mental health. Finally, we present two cases, one with video vignettes using the OCF and information obtained by use of the Cultural Formulation Interview (CFI), to illustrate how taking women's cultural identity and biology into account can shape assessment and treatment recommendations. The use of a trauma-informed approach is also an important component of this work.

Women's Mental Health and the Women's Movement: A Brief History

From the earliest days of the history of medicine, Hippocrates' theory of the "wandering uterus" linked women's sexuality to emotional instability because the uterus was thought to be able to detach itself and wander around the body, attaching itself to other organs such as the heart (causing chest pain) or the stomach (causing gastrointestinal problems) and leading women to become "hysterical" (Meyer 1997). The treatment was therefore to "anchor" the uterus through pregnancy or through keeping the uterus moist via intercourse so that it would remain in place. Many other explanations and cures can be found in writings throughout the Mediterranean world over the following centuries (Allison and Roberts 1994; Rodin 1992). Theories around women's emotional instability survived up to the late 1800s and have had a great influence over the development of women's reproductive rights. The term *hysteria* has almost completely disappeared from the psychiatric literature, which has now evolved to describe somatization and medically unexplained symptoms, and falls under the realm of psychosomatic medicine, at the borderland between medicine and psychiatry. Histrionic personality disorder would be the equivalent description in DSM-IV-TR (American Psychiatric Association 2000) Axis II pa-

thologies, with close links to the other Cluster B disorders, including borderline personality disorder, and it is maintained in DSM-5, although without the multiaxial system (American Psychiatric Association 2013). Interestingly, the term *hysterical* has remained in use as a colloquial, often pejorative, word used to describe a state of emotional excess and loss of control.

Whereas first-wave feminism of the late nineteenth and early twentieth centuries in Europe and North America focused on women's suffrage (the right to vote), second-wave feminism of the 1960s and 1970s addressed a broader range of issues, including legal and workplace inequalities, family norms, sexual rights, and reproductive rights (Wood 2010). The development of an oral contraceptive pill, as championed by Margaret Sanger, led women to experience their sexuality without risk of becoming pregnant. In Boston, Massachusetts, the Women's Health Collective would go on to publish *Our Bodies, Ourselves*, a groundbreaking manual of women's health matters. The book is now celebrating its forty-first anniversary, and it details how women can take care of themselves and reduce the power differential in the physician-woman relationship (Boston Women's Health Book Collective 2011; www.ourbodiesourselves.org).

In a chapter titled "Women's Mental Health: From Hysteria to Human Rights," Astbury (2006) links the recognition of gender, women's social position, and awareness of the effect of violence toward women arising from development of second-wave feminism as increasingly important determinants of women's mental health. She argues that in order to explain higher rates of common mental disorders in women such as depression, anxiety, and post-traumatic stress disorder, "a model of women's mental health is required that moves beyond brain chemistry and biologic factors. At the very least, it is necessary to include events and experiences that themselves alter brain chemistry and activate biologic stress mechanisms that, in turn, potentiate poor mental health and damage self esteem" (p. 378). Research has shown that these childhood stressors, often related to psychological trauma and dysfunctional attachment relationships, may have lifelong effects not only on mental health but also on physical health (Bremner et al. 2010; Bureau et al. 2010; Felitti et al. 1998).

During the height of the women's movement in the mid-1970s, Judith Herman (1992) began her career in the study of psychological trauma, leading to the groundbreaking book *Trauma and Recovery*. She writes:

[C]linicians know the privileged moment of insight when repressed ideas, feelings and memories surface into consciousness. These moments occur in the history of societies as well as in the history of individuals. In the 1970s, the speakouts of the women's liberation movement brought to public awareness the widespread crimes of violence towards women. Victims who had been silenced began to reveal their secrets.... We began to receive letters from women all over the country from women who never before told their stories. Through them, we realized the power of speaking the unspeakable and witnessed first-hand the creative energy that is released when the barriers of repression and denial are lifted. (p. 2)

Through her work, Herman compares and contrasts the experiences of battered women, child abuse and incest survivors, war veterans, and prisoners of war. In her approach to healing from the effect of trauma, she emphasizes the importance of restoring connections between public and private worlds, individuals and communities, and men and women.

We are currently in the midst of the third wave of feminism, which is more diffuse than previous movements and inclusive of women of color from a diversity of backgrounds and ethnicities, including a global emphasis that includes the developing world; sexual orientation; abilities and disabilities; class backgrounds; and appearance, including body types (Wood 2010). This is a welcome development that allows for discussion of heterogeneity of culture and identity differences between women of all backgrounds. Lu et al. (1995) described this as "gender identity issues [interacting] synergistically with ethnic identity to shape one's cultural identity" (p. 488), with resulting implications for assessment and treatment. Issues of sexual orientation (lesbian, gay, and bisexual) also become important here but are more fully explored in Chapter 8, "Sexual Orientation."

Overall, the entire spectrum of the women's movement is described as "a collage of many movements that spans more than 170 years and include a range of political and social ideologies" (Wood 2010, p. 94). Many counter-currents and backlash antifeminist responses are also made by women who may prefer a return to hearth and home or another destiny of their own making. As with all other aspects of cultural identity, a woman's position on these issues cannot be presumed. In terms of clinical assessment, how a female patient identifies with the women's movement shapes her cultural identity, ex-

pectations, and life choices, and eliciting this knowledge can entail a complex discussion that should be explored in treatment (see Table 7–1).

The concepts of gender, social position, and human rights, and how they interrelate, are seen as an integral part of understanding the origins of, and possible solutions for, inequalities in women's health. Level of education, income, legal protections and freedoms, and social and professional opportunities are important measures of a woman's rights in society. However, these can be grossly affected when "gender based violence forces submission at an individual level, and, by engendering fear, defeat, humiliation and a sense of blocked escape, or entrapment, it reinforces women's inferior social ranking and subordination in the wider society" (Astbury 2006, p. 385). In *Gender and Its Effects on Psychopathology*, Frank (2000) writes:

Gender and gender role appear to be key determinants of the kind of psychosocial experiences we have, particularly the kind of experiences that many psychopathologists regard as related to psychiatric symptoms and syndromes. Men are rarely raped. Except for a tiny fraction of cultures in the late 20th century, women have rarely been exposed to combat. (p. xv)

Of course, this may be an overstatement because many men experience sexual abuse, particularly in childhood. Focusing on ensuring human rights for all, then addressing related issues such as demoralization, devaluation, and loss of autonomy, is needed to rectify these social imbalances.

Even within the culture of medicine in which we practice, there is a very recent history and, some would argue, ongoing existence of a glass ceiling where women are not given equal opportunities, mentorship, and promotion in academia and positions of authority. Although medical school classes are now composed of equal and sometimes greater numbers of female students than male students, these ratios are not observed at the faculty level. Numbers of women in Canadian medical schools have risen from 14.3% in 1968/1969 to 57.7% today (Sheppard 2011). In the United States, the gender breakdown of medical school applicants and enrollees is 53% male and 47% female, with an increase noted among minority applicants (American Association of Medical Colleges 2010). However, it was not until the 1980s that women rose to positions of leadership in mental health professional societies, with Dr. Judith Gold becoming the first woman president of the Canadian Psychiatric Association in

Table 7–1. Practical guide to culturally competent assessment on gender issues: identifying data/history of present illness and psychiatric history

	Sample questions	Comments	Cultural formulation
Identifying data			
Level of education, income, social opportunities, professional opportunities	Has your gender affected you in any of these areas (education, income, etc.)?	These areas are highly influenced by sociocultural factors.	Cultural Identity Cultural Stressors/Supports
	How do you balance your professional identity with your identity within the family/relationship?	Educating women is one of the main strategies in poverty reduction and improving family health in developing countries.	
	How is your role valued as a woman in your 1) culture, 2) family of origin, 3) current family? (Ask during the social or developmental history.)		

Table 7–1. Practical guide to culturally competent assessment on gender issues: identifying data/history of present illness and psychiatric history (*continued*)

	Sample questions	Comments	Cultural formulation
History of present illness (where relevant)			
Menstrual issues	Have you noticed your mood being cyclically affected by seasons, weather, or your menstrual cycle?	<p>Screen for premenstrual dysphoric disorder.</p> <p>Some cultures have prohibitions against contact with menstrual blood, believing it to be unclean (e.g., Orthodox Jewish women need to bathe in the <i>mikvah</i> [ritual bath] every month after menses to cleanse themselves).</p> <p>Menopause can be interpreted differently in various cultures, with some critics asserting that there is medicalization of this phase of life in Western medicine.</p> <p>Postmenopausal women in some cultures have traditionally gained status as a matriarch with influence (e.g., <i>nai-nai</i> in Chinese, <i>nonna</i> in Italian, and <i>bubbe</i> in Yiddish: terms for grandmother).</p>	Explanatory Model

Table 7–1. Practical guide to culturally competent assessment on gender issues: identifying data/history of present illness and psychiatric history (*continued*)

	Sample questions	Comments	Cultural formulation
History of present illness (where relevant) (<i>continued</i>)			
Fertility issues	<p>Have you ever experienced any fertility issues? What was the effect on you and your family?</p> <p>Have you had any obstetrical or gynecological surgeries, including female genital mutilation? How do these affect you?</p>	<p>Women's fertility is highly valued in many cultures, even in many male-dominated cultures.</p> <p>Infertility can lead to great distress and a sense of failure.</p> <p>Even after children are born, hysterectomy for medical reasons may have psychological repercussions and may not be culturally accepted.</p>	<p>Explanatory Model</p> <p>Cultural Stressors/Supports</p>

Table 7–1. Practical guide to culturally competent assessment on gender issues: identifying data/history of present illness and psychiatric history (*continued*)

	Sample questions	Comments	Cultural formulation
Body image concerns	<p>Are you satisfied with your appearance and weight?</p> <p>Have you had any procedures that altered your appearance?</p> <p>Ask screening questions for eating disorders.</p>	<p>Ideals of beauty and appearance are culturally dependent, and physical appearance is often linked to a woman's self-esteem.</p> <p>Globalization has led to a spread of Western ideals about appearance. This has been linked to the rise of certain types of eating disorders as well as cosmetic medical procedures such as breast augmentation and Asian blepharoplasty ("double eyelid surgery").</p> <p>Historically, foot binding, corsets, neck rings, and other types of disfiguring procedures have been used to enhance physical appearance in different cultures.</p> <p>Medically necessary procedures such as mastectomy for breast cancer also can have great cultural and psychological significance.</p>	<p>Explanatory Model</p> <p>Cultural Stressors/Supports</p>

Table 7–1. Practical guide to culturally competent assessment on gender issues: identifying data/history of present illness and psychiatric history (*continued*)

Sample questions		Comments	Cultural formulation
History of present illness (where relevant) (<i>continued</i>)			
Household/child care issues	Who has the responsibility for household chores and child care? How are they shared?	Expectations about household routines are highly culturally determined, yet the routines often largely fall on women's shoulders. Depending on the culture, this may also be accompanied by a sense of mastery and control over household matters. In many cultures, there may be expectations that in-laws live in the home to help out or be cared for themselves.	Cultural Stressors/Supports

Table 7–1. Practical guide to culturally competent assessment on gender issues: identifying data/history of present illness and psychiatric history (*continued*)

	Sample questions	Comments	Cultural formulation
Relationship issues	Are you in an intimate relationship?	In many cultures and religions, dating before marriage may not be acceptable. However, in Western and other cultures, it is expected, and lack of dating experience may be negatively perceived (see case of Ms. Diamond).	Cultural Stressors/Supports
	How is your relationship with your partner?	In Western culture, there may be greater emphasis on the nuclear family than on extended family. Inequality between partners in the home may be a source of tension, especially if there are cultural differences or issues arising from acculturation.	Cultural Stressors/ Supports

Table 7–1. Practical guide to culturally competent assessment on gender issues: identifying data/history of present illness and psychiatric history (*continued*)

	Sample questions	Comments	Cultural formulation
History of present illness (where relevant) (<i>continued</i>)			
Relationship issues (<i>continued</i>)	How is your relationship with your family? With your in-laws?	In many cultures, there may be tension between women and their in-laws, especially mothers-in-law, which may be related to power struggles and a wish to have the husband's/son's support and attention.	Cultural Stressors/Supports
	How is your relationship with your children? Are they living with you?	There can be intergenerational conflict due to differences in acculturation. Relationships can change as children become young adults; this can affect the marital relationship as children leave home, especially if the woman's identity is substantially linked to being a mother (empty nest syndrome).	Cultural Stressors/ Supports

Table 7–1. Practical guide to culturally competent assessment on gender issues: identifying data/history of present illness and psychiatric history (*continued*)

	Sample questions	Comments	Cultural formulation
Intimacy issues	Would you describe any problems with your sex life?	<p>In some cultures, you may not be able to ask the question directly, especially when you first get to know your patient; indirect questions about aspects of marital life may be more acceptable.</p> <p>Screen for DSM-5 sexual dysfunctions (e.g., female sexual interest/arousal disorder, female orgasmic disorder) and other disorders (dyspareunia, vaginismus).</p> <p>History of trauma may have an effect (see below).</p> <p>Many other factors, including demands of modern life such as sleep deprivation and home and work responsibilities, medical conditions, and personal choice, may also affect sexual interest and functioning and should be considered to avoid overdiagnosis.</p>	Explanatory Model

Table 7–1. Practical guide to culturally competent assessment on gender issues: identifying data/history of present illness and psychiatric history (*continued*)

	Sample questions	Comments	Cultural formulation
History of present illness (where relevant) (<i>continued</i>)			
Separation/Divorce	Have you gone through separation or divorce before?	Traditional cultural values about marriage and nonacceptance of divorce may make it difficult to leave nonworking relationships, even abusive ones. Some separated or divorced families may still live together for practical or cultural reasons.	Cultural Stressors/Supports
Recent history of trauma	Is there any form of abuse or violence in your current or recent relationships? Or any gender-based violence in any other situation?	Ensure that the woman is safe in her home. If not, work to understand the situation from a cultural perspective and collaborate on creating an acceptable safety plan. Become familiar with community resources, such as women's shelters, hotlines, and legal advice. Supportive therapy is extremely important in these situations.	Cultural Stressors/Supports Relationship With Clinician

Table 7–1. Practical guide to culturally competent assessment on gender issues: identifying data/history of present illness and psychiatric history (*continued*)

	Sample questions	Comments	Cultural formulation
Legal protections and freedoms	<p>Have you experienced any gender-based discrimination?</p> <p>Have you experienced a “glass ceiling” at your work?</p>	<p>It can be important to educate newcomers and immigrant women about their legal rights in North America to help them empower themselves.</p> <p>Continuing to work against gender-based discrimination around the world through advocacy is needed (e.g., women not being able to drive in certain countries; Saudi Arabian women were granted voting rights only in 2011; harsh punishments, even death penalty, for adultery).</p>	Cultural Stressors/Supports

Table 7–1. Practical guide to culturally competent assessment on gender issues: identifying data/history of present illness and psychiatric history (*continued*)

	Sample questions	Comments	Cultural formulation
Psychiatric history			
Postpartum depression	<p>Have you ever experienced baby blues/depression/mood changes shortly after giving birth?</p> <p>Did you perform any cultural postpartum rituals? Did you experience any stress or benefits related to this?</p> <p>Do you feel you have adequate social support in your postpartum period?</p>	<p>Postpartum rituals may include dietary and activity proscriptions and restrictions and organized support. Postpartum rituals can also include different ways of dealing with the placenta, decisions about baby care such as breast-feeding, and circumcision for male babies. Certain rituals may especially cause problems when they cannot be performed in North America, either because of logistics (e.g., burying a placenta in an apartment) or because of legal restrictions (e.g., female circumcision). Rituals can be a source of support or stress.</p> <p>Unwanted social support (e.g., from a mother-in-law) has been linked to worsening of postpartum depression.</p>	<p>Explanatory Model</p> <p>Cultural Stressors/Supports</p>

1981 and Dr. Carol Nadelson becoming the first woman president of the American Psychiatric Association in 1985 (Canadian Psychiatric Association 2006; National Library of Medicine 2011). The glass ceiling continues to be an issue in faculty development and promotions.

Greater awareness of our own history with regard to gender inequities, professional identity, and the existence of power differentials within the culture of psychiatry is needed. Globalization of the Western biomedical model may have exported some of these hierarchical constructs to low-income countries as an unintended consequence. Of course, different family structures and social and cultural values are implicated as well. In situations where medical resources are lacking, explicitly highlighting the importance of women's mental health in manuals for developing countries such as *Where There Is No Psychiatrist* (Patel 2003) sends an important message to all health care workers, with statements such as "the promotion of gender equality, by empowering women to make decisions that influence their lives and educating men about the need for equal rights, is the most important way of promoting women's mental health" (p. 229). Useful suggestions about how to inquire about domestic stress, obtain collateral history from husbands and relatives, ensure follow-up for women, and start support groups and advocacy initiatives are also included. Patel (2003) writes that as a health service provider "you must be constantly aware of the powerful role played by gender inequality in the health of women. There are many ways in which you can help reduce the impact of this inequality on women's mental health" (p. 229) and offers the following clinical examples:

- If a woman presents repeatedly for minor health problems, take time to ask about her domestic situation and other stresses and how these may be affecting her physical and mental health.
- With the woman's permission, speak to her husband and family members, explain the difficulties the woman is facing, and educate them about how this situation may be affecting her health.

Treating health complaints in men and women with equal concern is important because it is well known that in many places,

[W]omen with any health problem are less likely to receive the same quality of health care as men. Women's complaints are taken less seriously by relatives and health workers. Women who are depressed often do not get the right treatment for their problems; instead they are prescribed sleeping pills and vitamins. Mentally handicapped girls are less likely to be sent to special schools. Whereas a mentally ill man may get married, mentally ill women are often left alone. Mentally ill women may be severely condemned for any behavior that could be perceived as a violation of feminine nature, such as lack of attention towards the preparation of food or neglect of children. Mental illness in women may be seen as a disgrace to the family. Many mentally ill women receive little social support. Married mentally ill women are more likely to be sent back to their parental home, deserted or divorced. (Patel 2003, p. 228)

Allowing women time to speak about their problems and concerns and providing psychoeducation about symptoms and mental health conditions for the woman and her family, counseling, and suggestions on improving relationships are all mentioned in Patel's (2003) manual as means of promoting mental health for women.

On a social level, bringing a discussion of women's mental health issues to local women's groups and forming self-help or support groups for women with mental health conditions if none exist are also community-building recommendations in the manual.

It is also important to mention that if language differences are present, working with professional interpreters rather than asking husbands or family members to translate is vital so that women's voices can be heard directly. Cultural consultants, also known as cultural brokers, with "insider knowledge" or specific cultural knowledge can also provide useful context and collateral information for assessments (Andermann 2010).

In research settings, women and ethnocultural minorities now need to be included in study populations in order for those studies to provide valid and generalizable results. The National Institutes of Health (2001) has mandated that any funded research must be able to capture information about both sexes and diverse racial and ethnic groups, as well as show whether an intervention affects these groups differentially. The era of the "70-kg man" is now in the past.

Epidemiology and Psychopathology

Some well-known gender differences in psychopathology have been consistently observed in several epidemiological studies. Women tend to have a higher prevalence of mood and anxiety disorders, except for bipolar disorder, whereas men have higher prevalence of externalizing disorders such as substance use disorder. Recent research, such as the World Health Organization's World Mental Health Surveys, found this pattern to be consistent across 15 developed and developing countries (Seedat et al. 2009). By examining traditional gender role variations across age cohorts and countries, the study found that these patterns remained largely stable for most mental disorders examined. There were, however, a few notable exceptions, such as major depressive disorder and substance dependence. This finding, consistent with some of the previous studies on depression, suggests that increased gender equity may potentially lead to decreased depression among women, likely through decreased stress and increased opportunities and resources. It is noteworthy to mention one striking example in which culture and social context affect the difference in the usual pattern of suicides in the West, which typically shows higher rates of attempts in women and higher rates of completion in men, who use more lethal means. In parts of rural China, the reverse is true, likely because of psychosocial and cultural factors, including availability of lethal pesticides (Law and Liu 2008). Of additional concern, the suicide rate in China is described as two to three times the global average, with low rates of depression and mental disorders found, giving financial or relationship stressors more prominence in the etiology of suicide.

Many factors interact to modify the prevalence rates of mental disorders among women. For example, a multisite community-based U.S. study with more than 3,000 women oversampled for minority women found that depressive symptoms as measured by the Center for Epidemiologic Studies Depression Scale (CES-D) significantly differed by race and ethnicity (Bromberger et al. 2004). In this study, 27.4% of African American and 43.0% of Hispanic American women had CES-D scores greater than 16, versus 22.3% of white American women; Chinese and Japanese American women had lower prevalence rates of 14.3% and 14.1%, respectively. The racial/ethnic differences were no longer significant when socioeconomic factors were accounted for. The study findings also suggested that the effect of socioeconomic factors

might be partly mediated by differences in physical health and psychosocial stressors among the groups.

Postpartum depression (PPD), often defined as depression occurring within the first year after childbirth, may affect as many as 7.1% of women in the first 12 weeks and up to 19.2% if minor depression is included (Gavin et al. 2005). In a review of PPD among immigrants (Fung and Dennis 2010), several Canadian studies suggested elevated prevalence of PPD among immigrant or refugee populations. However, some of the studies comparing U.S.-born with foreign-born mothers suggested either no difference or a lower rate in the latter. Foreign-born mothers may have certain culturally protective factors. Another complicating factor in interpreting these findings is that of ethnicity because black and Hispanic mothers were found to have higher levels of depressive symptoms than white mothers in several U.S. studies. Similarly, postpartum immigrant women from minority groups had higher rates of depressive symptoms than did either Canadian-born mothers or immigrant mothers from majority groups in a Canadian study. In all cases, a thorough safety assessment is required, which includes both suicidal and homicidal ideation, particularly asking about whether the patient has thoughts of harming the infant or infanticide (Table 7–2).

For schizophrenia, no sex difference is observed in most studies of prevalence rates, but the incidence rate estimates have been consistently higher in women than in men (Abel et al. 2010). Compared with men, women have a broader distribution in the age at onset of schizophrenia and a more prominent second peak around middle age. Women tend to have more affective symptoms, whereas men may have more negative symptoms. A later age at onset, more affective symptoms, and fewer negative symptoms all have been associated with a better prognosis and are associated with being female in most studies. Biological studies showing hormonal interactions, particularly the protective effects of estrogen, can explain some of these differences between men and women (Blehar 2006; Seeman 2006; Vigod and Stewart 2009).

Clinical Assessment

At the level of clinical assessment, Table 7–1 shows how the clinician can integrate gender-specific questions into a standard interview. Topics such as

body image (weight), menstruation, surgeries, and history of PPD can be discussed during the history of the present illness and medical and psychiatric history. Important topics to cover during the developmental and social histories include gender roles, level of functioning, relationships, children, trauma, sexual history, and occupation (Table 7–3).

With regard to the mental status examination, some particular cultural areas of inquiry can inform the diagnostic assessment of psychopathology. This ensures that culture and gender issues are taken into account and avoids assumptions or mislabeling that can occur if a cultural lens is not used appropriately.

Developmental Issues in the Woman's Life Cycle

Childhood

When working with women (and men), taking a life cycle approach is important because an awareness of different developmental trajectories is an essential feature of understanding male and female patients (Andermann 2006). We provide a few examples to highlight each of these stages in different cultural settings. Seeman (2006) writes that “regardless of specific diagnosis, females almost always express psychological distress somewhat differently than males. Age is a key factor between the two” (p. 3). She goes on to describe the preponderance of boys identified in child mental health services, with higher rates of hyperactivity syndromes, autism, learning disabilities, conduct disorders, anxiety, and depression. These problems are overtaken at the time of puberty, when rates of psychiatric illness suddenly change. In adolescence and beyond, most disorders, with the exception of substance abuse, schizophrenia, and impulse-control disorders, are found in girls and women.

Childhood is a time of exponential growth and learning in the physical, psychological, and cognitive spheres, including mastery of language and social interactions with the intimate family and the wider world. Culture is absorbed into the consciousness of the child during all aspects of family life, including daily routines; playtime; meals; social occasions; religions and festivals; and contact with siblings, parents and grandparents, extended family, teachers, neighbors, and communities (Andermann 2006). There are many theories of child development in the literature, but less is known about how culture affects

Table 7–2. Practical guide to culturally competent assessment on gender issues: mental status examination

	Sample questions	Comments	Cultural formulation
Mental status			
Appearance	<p>Inquire about the meaning of the patient's clothing, fashion choices, piercings, or tattoos.</p> <p>I notice that you are wearing a headscarf. Can you share with me what that means to you?</p> <p>I notice that you have a tattoo. What does that mean to you?</p> <p>How many tattoos do you have?</p> <p>When did you get them and why?</p>	<p>Explore cultural or religious meaning (e.g., a tattoo may be used to ward off evil spirits; <i>hijab</i> [headscarf] worn by Muslim women). This may also include subcultures that certain youths identify with and may be of developmental significance.</p> <p>The meaning of provocative dress may need to be explored gently rather than jumping to conclusions.</p>	Cultural Identity

Table 7–2. Practical guide to culturally competent assessment on gender issues: mental status examination (*continued*)

	Sample questions	Comments	Cultural formulation
Mood/Affect	<p>You seem embarrassed about crying; do you have certain concerns about crying here?</p> <p>You don't seem angry even though you just described a very difficult situation you experienced; how do you express your anger?</p>	<p>Emotional expression and display (e.g., crying) are highly culturally influenced.</p> <p>Although there may be stereotypes that women cry more easily than men, in a clinical setting, women may often apologize for crying or feel that it is inappropriate.</p> <p>Women who have experienced trauma or abuse may harbor a lot of anger, and this may be directed at themselves (e.g., self-harm in severe cases) or others.</p>	<p>Explanatory Model</p> <p>Relationship With Clinician</p>

Table 7–2. Practical guide to culturally competent assessment on gender issues: mental status examination (*continued*)

	Sample questions	Comments	Cultural formulation
Mental status (<i>continued</i>)			
Suicidal ideation	<p>Do you sometimes feel that life is meaningless and hopeless?</p> <p>What are your reasons for living?</p> <p>How does your faith or culture view self-harm or suicide?</p>	<p>Screen for suicidal risk using standard practice, keeping in mind that in some cultures it may be taboo to talk about death or suicide; begin with indirect questions such as about hopeless and passive suicidal thoughts.</p> <p>Women from most cultures attempt suicide more than men but have a lower completion rate because of the tendency to use less lethal means; there may be cultural exceptions, such as women from parts of rural China; we do not know how this may affect immigrant women from these areas.</p> <p>Because divorce and leaving a marriage may not be culturally acceptable, some women may feel especially trapped and hopeless, leading to suicidal thoughts.</p>	Explanatory Model

Table 7–2. Practical guide to culturally competent assessment on gender issues: mental status examination (*continued*)

	Sample questions	Comments	Cultural formulation
Homicidal ideation	Do you ever feel so hopeless that you want to end it all for you and your children?	It is important to screen for infanticidal ideation in cases of suspected postpartum depression.	Explanatory Model

Table 7–3. Practical guide to culturally competent assessment on gender issues: assessment of personal history

	Sample questions	Comments	Cultural formulation
Personal history			
Developmental cultural influence	How were you raised as a girl? What are the cultural expectations for a woman such as yourself from your parents? From your community? What do you see as a future for yourself?	Gender identity is shaped by family and cultural influences from birth onward (e.g., cultural meaning of names, dress, choice of toys and gifts, activities, schooling, allowable behaviors such as being encouraged to speak or play in a certain way).	Explanatory Model
Rites of passage	Have you ever participated in rites of passage in your culture?	Examples include bat mitzvah (Jewish coming-of-age ceremony for women); quinceañera (celebration of fifteenth birthday in the Hispanic community). Inquire about female genital mutilation in immigrants from African and Middle Eastern countries and its effect medically and psychologically.	Cultural Identity

Table 7–3. Practical guide to culturally competent assessment on gender issues: assessment of personal history (*continued*)

	Sample questions	Comments	Cultural formulation
Identification with women's movement	What do you think about the feminist movement? Where do you see yourself relative to the movement? How does this affect your life choices?		Cultural Identity Relationship With the Clinician
Marital arrangement	How did you meet your partner? Were you able to freely choose? What role did your family play in this union?	Adult arranged marriages are common in many cultures. Childhood arranged marriages are prohibited in many countries but may still be practiced (e.g., India). Common-law arrangements are increasingly common as a result of Western and modern influences.	Cultural Stressors/Supports
Sexual orientation	Are you attracted to men, women, or both? Have you had sexual fantasies, experiences, or relationships with men, women, or both?	See Chapter 8, "Sexual Orientation."	Cultural Identity

Table 7–3. Practical guide to culturally competent assessment on gender issues: assessment of personal history (*continued*)

	Sample questions	Comments	Cultural formulation
Personal history (<i>continued</i>)			
Past trauma	Have ever experienced any physical, sexual, or emotional abuse?	<p>Culture can affect what is perceived as abuse (e.g., spanking).</p> <p>History of trauma can affect future relationships and predispose toward mood and anxiety disorders.</p> <p>Age and developmental stage at which trauma occurred frame the experience and can change its effect.</p> <p>With appropriate supports, women can be quite resilient, and rates of posttraumatic stress disorder are much lower than are the relatively higher rates of exposure to trauma in women.</p>	<p>Explanatory Model</p> <p>Cultural Stressors/Supports</p>

Table 7–3. Practical guide to culturally competent assessment on gender issues: assessment of personal history (*continued*)

Sample questions	Comments	Cultural formulation
Past trauma (<i>continued</i>)	<p>Gender-based violence, especially rape, often leads to shame, which must be dealt with in therapy; victims often blame themselves for getting into unsafe situations; depending on the cultural circumstances, family members and even the legal system may blame the victim for her actions.</p> <p>Incest occurs in all cultures but is usually highly stigmatized; it can be devastating for victims when their accounts are not believed by their family members, and they may be blamed instead.</p>	

this critical period and how culture itself is learned. However, it is known that learning culture starts early: Notman and Nadelson (1995) said that “the role of particular cultural practices, including gender differences in child rearing, are manifest from infancy. Differences in parental behavior, especially those related to concepts of male and female roles, are powerful forces contributing to differences in male and female development” (p. 2).

Children learn through observation and imitation. In traditional aboriginal societies, boys and girls would follow the same-sex parent throughout the day, learning the sex-specific tasks required for hunting and survival (Balicki 1970). Through detailed ethnographic investigation, psychological anthropologists have studied the emotional education of young children and investigated the ways in which culture is learned (Briggs 1998). The developmental history is an important phase of the interview when gender-specific information can be obtained, such as child-rearing techniques of the patient’s parents, history of abuse as a child, rites of passage, feminist beliefs, cultural practices around marriage, and sexual orientation (see Table 7–3).

Carol Gilligan’s (1982) well-known study of the differences in psychological development between the sexes, *In a Different Voice*, describes how learning about gender roles and cultural expectations takes place in a mainstream North American setting. Through interviews with different age groups, this study was one of the first to explore gender-based conceptions of the self and women’s position in society or, as she pithily described it, “women’s place in the man’s life cycle” (Gilligan 1982). Even from a young age, girls were found to value interpersonal relationships and organize their social worlds according to principles of connectedness, whereas boys were more logical and hierarchical. Tensions between women and men can be traced to these different approaches to relationships, valuing connectedness versus hierarchy. Both of these exist in parent-child relationships and continue to be negotiated in family relationships as the child develops and goes out into the world. School-based formal learning and literacy are another important means of cultural learning and social development in childhood (Andermann 2006). Gender roles are learned from the family of origin from birth onward, beginning with name choices and subsequently through attitudes toward girls or boys about clothing, activities, and behaviors that are encouraged; self-expression; and choice of gifts such as dolls and tea sets versus train sets and soccer balls. Of course, these examples represent simplifications, and choices and expectations

faced by families are much more complex in reality and will vary in different cultures and contexts (see Table 7–3).

Adolescence

The development of sexual maturation as girls approach puberty occurs incrementally, beginning with hormonal and physical changes, then development of secondary sexual characteristics, and, finally, the onset of menarche. Moving toward a woman's reproductive years, and the potential for pregnancy, can be viewed as a time of "anxiety and risk" (Notman and Nadelson 1995). Girls gravitate toward peer groups at this time, moving beyond the family of origin for support, and issues of self-esteem, self-confidence, and physical attractiveness come to the forefront. Puberty rituals are commonly performed in many cultures to mark this time of change (Andermann 2006), such as a bat mitzvah (Jewish coming-of-age ceremony for girls at age 12), quinceañera (celebration of a girl's fifteenth birthday in Hispanic cultures), a debutante ball, or a sweet sixteen party (see Table 7–3).

One cultural tradition that still occurs mainly in Africa and the Middle East, including among immigrants from these backgrounds now living in developed countries, is female circumcision, also known as female genital mutilation. This may occur at the time of puberty or even much earlier to guarantee a woman's virginity and diminished sexual pleasure. It is a painful procedure fraught with medical and psychological complications, as well as a greater risk of HIV transmission and fertility and childbirth complications (Amnesty International 2004).

Anthropologist Janice Boddy, who has studied female circumcision in Somali culture, writes that

female fertility is highly prized; it is associated with plenty, prosperity and life, with the continuation of the lineage through the birth of sons, and with the virtues of pity, mercy, and compassion. Nevertheless, women are considered socially less developed than men. They regularly and involuntarily menstruate; they give birth and lactate; and when pregnant, they publicly display their sexuality and their ties to other humans. All these natural conditions that women cannot control are seen to represent weakness and a lack of independence, the antithesis of the social ideal (Barnes and Boddy 1995, p. 38).

Yet despite the trauma and morbidity, older women often are the ones ensuring the continuity of this ritual. More education and advocacy are needed to allow women to make better-informed decisions about their own reproductive health (Amnesty International 2004).

Historically, the practice of foot binding in China similarly placed women's bodies and their eligibility for marriage under the control of a patriarchal family system (Lim 2007; Walsh 2011). Many traditional Asian societies also arranged marriages through family connections.

In Westernized cultures, the prevalence of cosmetic surgeries is increasing in women of all ages, and the practice is spreading rapidly through globalization. These procedures include face-lifts, breast enhancement, liposuction, and, more recently, even cosmetic vaginoplasty, which, ironically, seems to come full circle with the female genital mutilation practices described earlier (Picard 2012a). Also, many adolescent girls seek out facial piercings and tattoos. Clinicians should ask about the circumstances of these and their meaning for the female patient (see Table 7-2).

In contrast, keeping young women's bodies covered, for example, by wearing long sleeves, long skirts, or various head coverings, can be an important sign of modesty and respect in many cultures. These practices can be seen as a form of male domination by those outside the culture and some within it, whereas others argue for respect for cultural and religious traditions and that women may choose to uphold these traditions. However, the extremes taken by the Taliban regime in Afghanistan, where girls were prohibited to go to school and all women had to wear a burka (full body covering with eyes showing), are clear examples of suppression of women's rights and gender equality. Families who immigrate to Western countries may have to deal with these issues as acculturation conflicts arise with the younger generation, who may defy traditions. These conflicts can sometimes result in gender-based violence, including "honor killings," documented in Canada, the United States, and Europe, as well as in some Middle Eastern and Asian countries. See Table 7-2 for sample questions to ask the patient if there are any cultural or religious reasons for not committing suicide or homicide.

Adulthood

Women's work and motherhood have been the main tasks in the adult lives of many women worldwide (Andermann 2006). In many places, childbearing begins in adolescence, and early teenage pregnancy is common in many cultures and subcultures. However, this is far from universal. With the rise of the women's movement in the 1960s, choices about reproduction came under full control of women for the first time, with widespread availability of the birth control pill, followed by other forms of contraception. North American courts became a battleground for abortion legislation and women's right to choose during subsequent decades. Some of these issues continue to be at the forefront today given newer reproductive technologies and their interpretation by social currents that may take more conservative or religious directions.

The advent of ultrasound technologies, which allow for early screening of medical problems and let parents know in utero the sex of the fetus, has also had unintended consequences. In some cultures, there is a strong preference for male offspring, for reasons of heredity and lineage, and some parents have used this early knowledge to determine the outcome of pregnancy, favoring male births (Andermann 2006). In China, India, the Middle East, and other countries where male births are favored, "missing women" have been documented at very high rates, up to 100 million globally (Desjarlais et al. 1995). The existence of the one-child policy in China raises the stakes for a male birth even higher. Many Chinese girls from mainland China end up in orphanages for adoption to childless couples from the West (United Kingdom, United States, and Canada). As a result, young men from China have a smaller group of women to choose from for a potential partner. Some of these sex-selection practices have also migrated to North America and are causing much debate (Friesen and Weeks 2012; Picard 2012b). In addition, socioeconomic and demographic changes in China have led to the adoption of new attitudes among women toward postponing marriage and falling marriage rates (Economist 2011).

Pregnancy

During pregnancy, there may be particular cultural dietary and behavioral proscriptions to which women are expected to adhere to ensure a healthy infant, and at times, these proscriptions are even thought to influence the sex of

the infant. In the postpartum period, many cultures also have well-defined cultural practices. Often, in a period lasting from a month to 40 days, some cultures emphasize organized support for the mother, periods of restricted activity and rest, dietary prescriptions and proscriptions, special hygiene practices, and ritualized infant care practices (Dennis et al. 2007). For example, in cultures that have humoral theories about health, such as traditional Chinese medicine, women may be restricted from being in contact with the “cold,” which may refer to elements of the environment such as wind or certain types of foods designated as “cold” (referring not to the temperature of the food but to its qualities).

The most active psychologically protective element in these rituals is likely the organized support component, often involving the patient’s mother or mother-in-law caring for the new mother, although evidence is insufficient to conclusively determine whether postpartum rituals actually prevent PPD (Grigoriadis et al. 2009). Immigrant women who want to practice these rituals but cannot for various reasons, such as in the case of Hmong women who wish to bury the placenta in their home (Fadiman 1998), may find this inability to perform the rituals stressful. In some communities in North America and Asia, private centers provide traditional postpartum rituals and support not otherwise available to mothers. Interestingly, some cultural traditions from other parts of the world also affect mainstream North American health practices, such as the sudden interest in using placental parts for their nutritional content (placentophagy). Some postpartum rituals, however, may lead to increased stress if tensions exist between the prescribed caregiver and the new mother, such as situations of interpersonal conflict with a mother-in-law.

Aging

As women approach menopause, they make the transition to postreproductive life. Cultural interpretations of this biological event can vary enormously (Tseng 2003). Cross-cultural studies of menopause in Japan and North America, where menopause is treated more as a medical condition, with hormone replacements and drugs, can illustrate these differences (Lock 1993). The empty nest syndrome, when children leave the home, can result in the development of depression or can be a period of growth for the woman, now freed of her childbearing responsibilities (Mitchell and Lovegreen 2009). Retirement

ment is also a time of stress and change for women, particularly if this results in a financially precarious position late in life (Tseng 2003). In women with preexisting mental illness, decreases in hormone levels are also hypothesized to lead to worsening outcomes for older women with schizophrenia, who may have done relatively well compared with men with the same disease, after losing the protective effects of estrogen (Seeman and Lang 1990).

However, the status of women may improve once they are freed from the restrictions of child-raising and homemaker duties. This change in status may also result in marital stress due to changes in the dynamics between the two partners, and divorce may follow. Women of a certain age can gain authority and respect as elders in the community (Andermann 2006). Their experience is valued and provides knowledge for younger generations. In some circumstances, such as in countries with high prevalence of HIV or teenage pregnancy, grandmothers can be pressed into service again to care for orphaned grandchildren or children who cannot be cared for by their parents.

With regard to end-of-life issues, rituals around death and mourning vary enormously among cultures. Representations of women continue even beyond death. This can affect the living, such as future generations of women being influenced by a deceased matriarch (Andermann 2006). It can also involve the cosmological or spiritual sphere. In clinical situations, these beliefs and expectations need to be explored and discussed, independently or together with family, according to a woman's preference.

DSM-5 Outline for Cultural Formulation

In this section, we present two brief case examples. This is followed by a discussion of the relevant issues under the DSM-5 OCF, referring to Case 1 and Video 6 (Case 2) (American Psychiatric Association 2013). For examples of questions that may be asked, see Table 7–1 for the history of present illness, cross-referenced with the OCF; Table 7–3 for the cultural identity of the individual; and Table 7–2 for the mental status examination.

Case 1

Ms. C. is a 39-year-old married woman who immigrated from China 6 years ago and is living with her husband and 13-year-old daughter. She works in a bank as a financial adviser. Her husband works part-time in a contract job do-

ing information technology consultant work. She was referred for dysthymia and depression. She complained of dizziness, chest discomfort, and fatigue, which had not been alleviated by herbal medicine or the selective serotonin reuptake inhibitor prescribed by her family doctor.

In the interview, she discussed several stressors. She was passed over for a promotion, which went to a Caucasian male coworker who was her supervisor's golfing partner. Her chronic stressors included conflicts with her mother-in-law, who came from a different part of China and was upset with her for giving birth to a girl. Ms. C. and her husband became Christian a few years after immigration, finding great support from the local pastor, but this further worsened her relationship with her mother-in-law, who was a Buddhist. Ms. C.'s marital relationship began to deteriorate. She felt hurt that her husband was too obedient to his mother and did not side with her. She also felt disappointed that he lost his drive and ambition after immigration. His English was still not fluent, and he hardly talked at home. Several times, they had minor physical fights, but police were called and gave her husband a warning, and he now avoids fights by further retreating and staying silent.

Growing up, Ms. C. came from an intellectual family that survived the Cultural Revolution. She recalled having a very close relationship with her father, whom she admired until he had an extramarital affair, which eventually led to her parents' divorce when she was 23. She graduated from a university in China with a degree in commerce and English studies. In her late teens, she was molested in a movie theater by a man who promised her that he would cast her in a local television show; she felt very ashamed and foolish about the incident and never told this to anyone. Before meeting her husband, she had a 2-year relationship that she ended because her parents did not approve of her boyfriend's family background. Her family instead introduced her to her future husband, and they married after 6 months. Her current supports include her mother, who has a chronic medical illness in China; her younger sister, who has a successful life in France; and the pastor of her local church.

Case 2 (Video 6)

Ms. Diamond is a 38-year-old single woman living and working in New York City. She practices her Jewish religion but identifies more strongly with her Jewish cultural heritage. She is very involved with her family, who live nearby, and sees them regularly for monthly family dinners, visits, and celebrations with her parents, married sisters, nieces, and nephews. She speaks to her mother daily on the telephone. Her grandmother was a Holocaust survivor. Although she enjoys seeing her family, she also experiences these get-togethers as a burden but cannot refuse to attend these events, which take up much of her weekend and personal time. She was frustrated and angry at her family's

expectations of her but was unable to express this frustration and anger to them.

Ms. Diamond described her mood as being chronically depressed for many years and had tried numerous therapy modalities, including individual and group therapies. Her most recent psychotherapist, who was also of Jewish background, retired after 3 years of working together, and she is looking for a new therapist. She described experiences of anti-Semitism in her early school-age years and a sense of “not fitting in” with her classmates. This feeling of alienation was also present at home while she was growing up because she felt left out by her younger sisters, who were closer to each other in age. She also felt that attending Hebrew school on the weekends as a child took her away from other more enjoyable activities.

Cultural Identity of the Individual

An individual's cultural identities can be multifaceted and dynamic in time. The gender role of being a woman, as prescribed by culture, can be an important component of a woman's cultural identity, such as her relationships with men and, when in a relationship, her in-laws. Depending on the culture, a woman's gender role may take on different meanings at different developmental stages of life. For instance, the gender-related expectations of being a girl, such as how girls “should” speak, play, or behave, or even whether they should be schooled, are different from role expectations in adulthood, such as how women “should” behave at work or at home. Issues and challenges at earlier stages may have an indelible effect on development and have substantial relevance in later life (see Table 7–3).

In many patriarchal cultures, the cultural identity of a woman may be associated with being disempowered and weak. The concept of “silencing the self,” linking the existence of depression to gender roles in a social world, has been developed to explain the discrepancies in rates of depression between men and women across cultures (Jack and Ali 2010). Many more positive attributes may also be ascribed to the feminine cultural identity, such as loving, caring, nurturing, and understanding. Although these attributes can be positive and affirming, these stereotypes also can become a burden, causing some women to feel that they need to sacrifice themselves and attend to others' needs first. The meaning and identity of being a woman is a complex interaction of heritage cultures, particular life experiences, individual personality and choice, and current societal and environmental factors. As in many situ-

ations when inequities are present, how one responds to and situates oneself with regard to these inequities may itself become a defining identity, such as being a feminist. The meaning of feminism, however, can be different to each individual woman.

Questions to assess the gender role of a female patient include the following:

- What are the cultural expectations for a woman such as yourself?
- What is expected of you by your parents?
- What do you see as a future for yourself?

In Ms. C.'s case, aspects of her cultural identity that were important to her include being Chinese, a woman, a mother, a daughter-in-law, an immigrant, a white-collar worker, and an intellectual person. From an acculturation point of view, she showed an integration strategy because she embraced both North American culture and her heritage Chinese culture.

In Ms. Diamond's case, watch Video 6–1 and try to describe her cultural identity. Come back to this section after viewing the video and see how close your assessment of her cultural identity is to the following. Be sure to pay attention to the questions that Dr. Boehnlein uses to get Ms. Diamond to elaborate on her cultural identity, such as "Did you go to any religious school or learn Hebrew?" During Dr. Boehnlein's safety assessment, Ms. Diamond states she has no thoughts of suicide because "it's way against my religion," giving Dr. Boehnlein an opportunity to explore an important facet of her cultural identity, her religion and spirituality. (See Chapter 10, "Religious and Spiritual Assessment," for further discussion of the role of religion in cultural identity.) Table 7–2 refers to how religion or culture may affect suicidality or homicidality.



Video Illustration 6–1: Cultural identity and religion (3:55)

Ms. Diamond's cultural identity is entangled with her family relationships. She identifies herself as a non-Orthodox Jew, a single woman, a daughter from a Jewish family, a sister and an aunt, and a granddaughter to a Holocaust survivor. She does not seem to perceive herself as being as successful in her career working in administrative support in a law office compared with

her sister, who is a dentist, although she is certainly independent and able to support herself financially and live on her own. With regard to dating, she sought to meet men of a similar Jewish background and had tried many strategies, including Jewish Internet dating sites. She had a previous serious relationship many years before that she hoped would lead to marriage but still felt hurt that her boyfriend had broken off the relationship when he went to medical school.

Cultural Conceptualizations of Distress

When encountering an illness and bodily discomfort, patients often develop a way of understanding the experience that can best be captured with an examination of the underlying explanatory model of illness. The model of illness can include elements such as the perception of the problem or illness, the cause of the symptoms and the illness, the appropriate and indicated treatment, and the severity and prognosis of the illness.

A study of 1,000 Southeast Asian immigrant women from five ethnic groups found that each group had different explanatory models of illness regarding the cause of mental illness and distress (Fung and Wong 2007). Furthermore, perceived access to care was a more important factor for most of these ethnic groups than was the explanatory model of illness per se in determining the women's attitudes toward seeking care. This points to the fallacy of assuming a homogeneous explanatory model of illness with large ethnic blocks such as "Asians" as well as the assumption that immigrants' beliefs are the main problem in health equity. Individual exploration of a patient's varied and sometimes conflicting and competing explanatory models of illness is most important clinically. If unexplored, this can affect the appropriate choice of treatment and the patient's acceptance of and adherence to treatment.

For Ms. C., although she presented with somatic symptoms, she also saw that her health problems might be related to her psychosocial stressors. As an immigrant with an integration strategy and a holistic understanding of health, she tried both traditional Chinese medicine and antidepressant medications and has been open to the idea of psychotherapy. Further exploration found that her understanding and expectations of the antidepressant medications and psychotherapy were based on a mixture of her own idiosyncratic interpretation of traditional Chinese medicine and newspaper articles in the Western media.

In discussions with patients, we can use Kleinman et al.'s (1978) eight questions (see Table 1–8) and pay particular attention to explanatory models that are gender based, such as whether this has happened in other men or women, or we can ask if there is any relation between the patient's symptoms and menstruation, menarche, or menopause. In Ms. Diamond's case, she had experienced various types of treatment and therapy and had her own thoughts about what would not work for her. In both of these cases, an understanding of the patient's explanatory model would help lead to a discussion and negotiation about what would be the best treatment plan.

Psychosocial Stressors and Cultural Features of Vulnerability and Resilience

Interpersonal relationships can be a positive source of support that can help to buffer against other sources of stress, but they can also be a major source of stress in themselves. In collectivistic cultures, harmonious relationships are an even more important ideal. In some hierarchical and patriarchal cultures, women are expected to be responsible for family functioning and maintaining harmony, sometimes through submission and obedience. For example, in traditional Chinese culture, women are expected to uphold the "Three Obediences" depending on their stage in life—to their father, husband, and son (Kramarae and Spender 2000). Although this power inequity is outdated in modern societal values, its remnants may still penetrate the dynamics of families, leading to oppression. Complicated family dynamics often lead to sources of stress, such as the conflicts or tension between a woman and her mother-in-law, as described earlier. In cases such as these, it may be helpful to talk to a mental health professional who is familiar with the cultural group (cultural consultant or broker) to find out more about culturally based gender roles. Table 7–1 would also be a useful source of questions for the interview.

In the case of immigrants and refugees, women may be able to find jobs more easily than men because of various factors, including better language skills and the availability of certain kinds of jobs such as retail and factory jobs. This can lead to a reversal of power within the family that can create tension and stress. In immigrant families, when the husbands are often away for business trips, extramarital affairs can become an issue and further erode the marital relationship. Immigrant families may also struggle with family conflicts

arising from cultural and generation gaps as their children become acculturated to the Western culture.

Trauma and violence are an important issue to explore. Refugee women might have suffered trauma due to war, as well as domestic or sexual violence, in their home countries. Among immigrant populations, single men might look for spouses from their home country and sponsor them to immigrate. In some of these cases, women encountering domestic violence might feel isolated, trapped, and disempowered from seeking help. Traditional cultural values about marriage and nonacceptance of divorce might be another factor that keeps some women from leaving an abusive relationship. The following questions would be helpful in exploring cultural values around marriage and divorce in diverse populations: Have you ever considered a divorce? What would your family and your community say or think if you had a divorce?

At the societal level, gender inequity can be a source of stress. In Ms. C.'s case, she felt discriminated against in her work because her career advancement was hampered by her not belonging to an "old boys' club." Furthermore, in her marriage, she had to deal with the conflict with her mother-in-law and the role reversal of finding her husband not adapting well to a new country, raising doubts about her choice of marital partner because she was influenced by her family to marry him. Ms. C.'s involvement in the church has been a source of support, but she also struggled with feelings of guilt related to her marriage and wish for a divorce. The clinician can ask if the patient's church group would support her desire for a divorce.

Ms. Diamond, being single and without children, had to deal with pressures from her family, who held a traditional Jewish view about the gender role of women being wives and mothers. She also had struggled with issues related to discrimination in the form of anti-Semitism since childhood, which added to her previous relationship losses and reinforced her sense of not being able to connect with and trust others. Dr. Boehnlein asked Ms. Diamond about expectations from her family, and she stated that her parents expected a lot from her and still do. She is the single one at their monthly family gatherings, as well as birthdays, sports parties, and so forth; her two sisters are married with children. Her summary comment is, "It's not subtle," emphasizing that her family is both a support and a stressor.

Cultural Features of the Relationship Between the Individual and the Clinician

Cultural elements that can powerfully affect the relationship may arise from the clinician or the patient. In classical therapeutic terms, a patient may have certain *transference* reactions toward the therapist (i.e., feelings based on her own gender, culture, history, and experience), while the therapist's feelings, *countertransference*, may also be subjected to similar influences from the therapist's own culture and experiences.

The gender of the therapist may become an important factor in building trust, especially because there is an inherent power inequality in a therapeutic relationship. Some women may prefer to have a female therapist, feeling that only other women can understand their experiences from a female perspective. This may be especially important for women who have experienced trauma, abuse, infidelity, or other forms of disappointment or negative experiences with men. Cultural or religious proscriptions or beliefs may also inhibit women from disclosing their feelings to a male clinician, especially on issues regarding sexuality. Conversely, some women may prefer male clinicians, having a "positive" bias due to cultural or personal beliefs or feeling less threatened by a sense of competition, comparison, and judgment. The gender of the therapist may be an issue in the initial intake evaluation or in the early, middle, or late phases of therapy, and the therapist needs to be ready to discuss it openly.

Strong negative transferences sometimes will completely prevent any engagement, in which case a referral to another clinician may be necessary. In other cases, positive and negative transferences may be more subtle or latent and still have an effect on the course of therapy if not explored and addressed.

As always, reflection of one's own countertransference is just as important because clinicians, regardless of gender, may fall prey to similar gender-related stereotypes and biases. Clinicians may feel overprotective toward certain female patients, seeing them as victims and not recognizing their strengths; less empathetic toward women whose "bad" behavior may be associated with certain stereotypes and who may be inappropriately labeled as having personality disorders; or even contempt toward women who behave against the clinicians' cultural gender expectations, such as being a feminist.

In Ms. C.'s case, she connected well with a male Chinese therapist. Despite her previous sexual abuse and disappointing experiences with her father,

husband, and job supervisor, she was able to develop trust with the therapist through early identification and explicit exploration of some of her difficulties with men. She described that what was most important to her was not feeling judged when she expressed doubts about her relationship with her husband and possible attraction to another man from her church.

Ms. Diamond confronted Dr. Boehnlein about his religion and culture. The therapist must understand how to answer this common question honestly and straightforwardly. We may wonder how Ms. Diamond would feel with a male therapist and how this could be different from her previous therapist, who was a woman (see Video 6–2). Note the tension between them and how Dr. Boehnlein reassures her that he understands her. She continues to test for his understanding.



Video Illustration 6–2: Transference and countertransference (5:18)

In Ms. Diamond's case, the clinician's open acknowledgment of potential trust issues at the conclusion of the interview was helpful in opening up a dialogue about possible transference issues. She had concerns about having a new therapist who was of a different religious background and who might not be able to understand her concerns and family expectations, and although not directly addressed, she noted that she had trouble with withholding male therapists and that her last therapist was female.

Overall Cultural Assessment

Diagnostically, both Ms. C. and Ms. Diamond have dysthymic disorder, and Ms. C. also has major depressive disorder. Ms. Diamond readily labeled herself as being depressed and was experienced with therapy, whereas Ms. C. presented with somatic "entrance complaints" with a limited familiarity with psychotherapy but was open to considering her psychosocial issues when explored.

Both women identified interpersonal relationships as sources of stress. Furthermore, their issues are embedded in a context that involved conflicts related to both culture and gender, which challenge their self-identity and their relationships with family and society. Inclusion of this cultural and gender

perspective helps to add an enriched understanding of their struggles in addition to their individual life experiences.

In treatment, the challenge will be forming a therapeutic alliance and building trust, as well as collaboratively determining the goals, process, and content of therapy (Lo and Fung 2003). In Ms. C.'s case, her self-identity and treatment involved a combination of antidepressant medication and psychotherapy. In the initial phase of therapy, the focus was on her frustration with her job. Responding to what she was most acutely frustrated with and working through some of the injustices she felt at work as an immigrant woman opened her up to talk more in depth about her more personal issues, including her relationships with her father and her husband. The therapy conducted was an integrative mix with elements of cognitive-behavioral therapy and acceptance and commitment therapy.

In Video 6–3, note how Dr. Boehnlein summarizes and formulates the case in the concluding phase of the interview. He presents a summary, acknowledging the challenges that they will have to face. Note how he uses the questions from CFI supplementary module 8, "Patient-Clinician Relationship," in assessing what has worked and what has not and what are the patient's expectations in therapy.

Video Illustration 6–3: Cultural formulation (6:20)

Ms. Diamond's self-identity involved a need to maintain cultural traditions, particularly those related to family and children. Following the Holocaust, issues around ensuring continuity of the Jewish faith have been seen as very important by that community. This may be an entrance point but has to be balanced with a deliberate transition toward exploring the patient's own wishes.

Ms. Diamond was, in fact, very close to her parents, with daily telephone contact with her mother; she also confronted the therapist quite early on for focusing the questions on her parents. Similar to asking if her therapist was Jewish, there was a strong sense that she wanted the therapist to truly understand her and stand by her side. Her feelings as an outsider, from her anti-Semitic experiences in school, to not being able to mingle with her younger sisters as a child, to being the only single woman among her sisters, have all added to her sense of alienation, which added to her trust and abandonment issues from the losses of her ex-boyfriends and previous therapists. The effect of her grand-

mother's experiences in the Holocaust on the upbringing of Ms. Diamond's mother and her own children would have to be explored further in light of understanding transmission of intergenerational trauma.

DSM-5 Cultural Formulation Interview

Gender-related issues can be found in each of the components of the OCF in DSM-5, as shown in Tables 7–1 through 7–3, which illustrate components of a culturally competent clinical interview on gender issues. Similarly, these issues can be clinically relevant in each section of the new CFI in DSM-5 (American Psychiatric Association 2013). However, the most direct questions about gender issues can be found in CFI supplementary module 6, “Cultural Identity.” These questions are preceded by a preamble to patients explaining that some individuals may feel that their gender (defined as the social roles and expectations they have related to being male, female, or intersex) may affect their health and health care needs. The questions are

26. Do you feel that your [GENDER] has influenced your [PROBLEM] or your health more generally?
27. Do you feel that your [GENDER] has influenced your ability to get the kind of health care you need?
28. Do you feel that health care providers have certain assumptions or attitudes about you or your [PROBLEM] because of your [GENDER]?

Other sections of the CFI where gender may be especially relevant can be found in the “Cultural Factors Affecting Self-Coping and Past Help Seeking” and “Cultural Factors Affecting Current Help Seeking” sections, which encompass the OCF section on cultural factors in the relationship between patient and clinician, where gender differences between patient and clinician are often raised. The interviewer should elicit concerns about perceived issues in the clinician-patient relationship, which may include power differences, age, and gender.

We have highlighted the importance of focusing on gender issues in clinical care, which are often overlooked. However, sensitive interviewers also need to respect areas that patients feel uncomfortable with or are not ready to discuss. Use of the suggested questions in Tables 7–1, 7–2, and 7–3 and in the

CFI supplementary modules must be done judiciously, with consideration and respect for the patient.

Conclusion

As described throughout this chapter, culture is woven through the lives of women with many intertwining effects on mental health and illness. Understanding the historical roots of women's mental health and the women's movement helps to trace the developments in societal views around gender and psychopathology. Mental health assessments with a gender-based focus ideally should involve a developmental approach that follows the life cycle of women, noting the different tasks, struggles, and accomplishments of each phase of life. These details are important clinically to be able to identify issues that may arise at different stages and address them appropriately. Assessments that sensitively inquire about trauma in the lives of women, past and present, in a supportive environment are necessary to fully understand experiences of violence and discrimination and how these may affect mental health. Noting the centrality of relationships in women's lives is key in understanding the stressors they face and the supports they have in a cultural framework, also taking into account the multiple identities they balance in different roles within and outside the family. Exploring the cultural aspects of women's mental health continues to be a developing area as we learn more about the effects of culture, immigration, acculturation, and globalization on mental health and experiences of illness at home and beyond.

Cultural Assessment of Gender: Summary of Key Clinical Skills

1. Take a life cycle approach and be aware of developmental life trajectory and its implications for mental health and illness.
2. Reflect on your own personal and cultural perceptions about women and their social roles and how this may affect your clinical work.
3. Be vigilant to screen for signs of hidden domestic abuse and violence (e.g., repeated complaints of minor health problems), while being mindful that this can potentially make the situation worse, especially if advice

is given without taking the cultural and situational context into consideration.

4. Rather than using the patient's husband or family members to interpret, it is important to use professional interpreters so that women's voices can be heard directly. If the husband interprets, important information may be concealed if he is the perpetrator of domestic violence.
5. Collateral history from the husband and family members (with the woman's permission) may be helpful in understanding complex family situations and to provide psychoeducation about how her current situation may be affecting her health.
6. Cultural consultants with "insider knowledge" or a cultural knowledge can provide useful context and collateral information for assessments.
7. Assessment of women who have been through past trauma needs to begin with creating a sense of safety and therapeutic alliance. Many traumas may be hidden and not identified unless specific inquiries are made. Women may prefer a female therapist. However, this may not always be possible. Identify and acknowledge that this may be an issue. With care, such transference issues may be worked through with a positive outcome.
8. Treatment recommendations should include social, emotional, and instrumental supports (e.g., child care, parenting classes, women's groups) as well as standard biological and psychological interventions. Support groups can be very helpful because they allow women to share and learn from common experiences in a relational way. Become familiar with community women's resources and share them with patients.
9. Be mindful of the central importance of relationships in women's lives and how these can be affected by the acculturation process (e.g., women becoming more independent financially or educationally may cause tensions at home and change the family dynamic). The child-rearing and acculturation stages of development can also lead to intergenerational issues and should be explored.
10. Empowering women through advocacy and by offering the highest standards of clinical care is the best way to work against social inequalities and to improve the mental health and outcomes of women in our communities and abroad.

References

- Abel KM, Drake R, Goldstein JM: Sex differences in schizophrenia. *Int Rev Psychiatry* 22(5):417–428, 2010
- Allison DB, Roberts MS: On constructing the disorder of hysteria. *J Med Philos* 19(3):239–259, 1994
- American Association of Medical Colleges (AAMC): Medical School Enrollment Shows Diversity Gains: Number of First-Time Applicants Also Up, Demonstrating Interest in Medicine as a Career (press release). Washington, DC, American Association of Medical Colleges, 2010. Available at: <https://www.aamc.org/newsroom/newsreleases/2010/152932/101013.html>. Accessed August 27, 2011.
- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000
- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Washington, DC, American Psychiatric Association, 2013
- Amnesty International: International Zero Tolerance to FGM Day: Effective Measures Needed to Protect Girls From Female Genital Mutilation (press release). New York, Amnesty International, February 6, 2004
- Andermann L: Women, culture and development, in *Women's Health: A Life Cycle Approach*. Edited by Romans S, Seeman M. Philadelphia, PA, Lippincott, Williams & Wilkins, 2006, pp 15–31
- Andermann L: Culture and the social construction of gender: mapping the intersection with mental health. *Int Rev Psychiatry* 22(5):501–512, 2010
- Astbury J: Women's mental health: from hysteria to human rights, in *Women's Mental Health: A Life Cycle Approach*. Edited by Romans S, Seeman M. Philadelphia, PA, Lippincott, Williams & Wilkins, 2006, pp 377–392
- Balikci A: *The Netsilik Eskimo*. New York, Natural History Press, 1970
- Barnes VL, Boddy J: *Aman: The Story of a Somali Girl*. Toronto, Vintage Canada, 1995
- Blehar MC: Women's mental health research: the emergence of a biomedical field. *Annu Rev Clin Psychol* 2:135–160, 2006
- Boston Women's Health Book Collective: *Our Bodies, Ourselves*. New York, Simon & Schuster, 2011. Available at: <http://www.ourbodiesourselves.org>. Accessed January 23, 2012.
- Bremner JD, Vermetten E, Lanius R: Long-lasting effects of childhood abuse on neurobiology, in *The Impact of Early Life Trauma on Health and Disease: The Hidden Epidemic*. Edited by Lanius R, Vermetten E, Pain C. New York, Cambridge University Press, 2010, pp 166–177

- Briggs J: Inuit Morality Play: The Emotional Education of a Three-Year-Old. New Haven, CT, Yale University Press, 1998
- Bromberger JT, Harlow S, Avis N, et al: Racial/ethnic differences in the prevalence of depressive symptoms among middle-aged women: the Study of Women's Health Across the Nation (SWAN). *Am J Public Health* 94(8):1378–1385, 2004
- Bureau J-F, Martin J, Lyons-Ruth K: Attachment dysregulation as hidden trauma in infancy: early stress, maternal buffering and psychiatric morbidity in young adulthood, in *The Impact of Early Life Trauma on Health and Disease: The Hidden Epidemic*. Edited by Lanius R, Vermetten E, Pain C. New York, Cambridge University Press, 2010, pp 48–56
- Canadian Psychiatric Association: Editor's interview: Dr. Judith Gold. *Canadian Psychiatry Aujord'hui* 2(5), 2006. Available at: <http://publications.cpa-apc.org/browse/documents/61>. Accessed August 13, 2011.
- Dennis C-L, Fung K, Grigoriadis S, et al: Traditional postpartum practices and rituals: a qualitative systematic review. *Womens Health (Lond Engl)* 3(4):487–502, 2007
- Desjarlais R, Eisenberg L, Good B, et al: *World Mental Health: Problems and Priorities in Low Income Countries*. New York, Oxford University Press, 1995
- Economist: The decline of Asian marriage: Asia's lonely hearts. *The Economist*, August 20, 2011. Available at: <http://www.economist.com/node/21526350?frsc=dg%7Ca>. Accessed January 23, 2012.
- Fadiman A: *The Spirit Catches You and You Fall Down*. New York, Farrar, Straus & Giroux, 1998
- Felitti VJ, Anda RF, Nordenberg D, et al: Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the Adverse Childhood Experiences (ACE) Study. *Am J Prev Med* 14(4):245–258, 1998
- Frank E (ed): *Gender and Its Effects on Psychopathology*. Washington, DC, American Psychiatric Press, 2000
- Friesen J, Weeks C: Bid to curb female feticide pushes hot buttons of abortion and culture. *The Globe and Mail*, January 16, 2012. Available at: <http://www.theglobeandmail.com/life/health/new-health/health-news/bid-to-curb-female-feticide-pushes-hot-buttons-of-abortion-and-culture/article2304046/>. Accessed January 23, 2012.
- Fung K, Dennis C-L: Postpartum depression among immigrant women. *Curr Opin Psychiatry* 23(4):342–348, 2010
- Fung K, Wong YL: Factors influencing attitudes towards seeking professional help among East and Southeast Asian immigrant and refugee women. *Int J Soc Psychiatry* 53(3):216–231, 2007

- Gavin NI, Gaynes BN, Lohr KN, et al: Perinatal depression: a systematic review of prevalence and incidence. *Obstet Gynecol* 106(5 Pt 1):1071–1083, 2005
- Gilligan C: *In a Different Voice: Psychological Theory and Women's Development*. Boston, MA, Harvard University Press, 1982
- Grigoriadis S, Erlick Robinson G, Fung K, et al: Traditional postpartum practices and rituals: clinical implications. *Can J Psychiatry* 54(12):834–840, 2009
- Herman J: *Trauma and Recovery*. New York, Basic Books, 1992
- Jack DC, Ali A: *Silencing the Self Across Cultures: Depression and Gender in the Social World*. New York, Oxford University Press, 2010
- Kleinman A, Eisenberg L, Good B: Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. *Ann Intern Med* 88(2):251–258, 1978
- Kramarae C, Spender D: *Routledge International Encyclopedia of Women: Global Women's Issues and Knowledge*. New York, Routledge, 2000
- Law S, Liu P: Suicide in China: unique demographic patterns and relationship to depressive disorder. *Curr Psychiatry Rep* 10(1):80–86, 2008
- Lim L: Painful memories for China's footbinding survivors. National Public Radio, March 9, 2007. Available at: <http://www.npr.org/templates/story/story.php?storyId=8966942>. Accessed January 23, 2012.
- Lo HT, Fung KP: Culturally competent psychotherapy. *Can J Psychiatry* 48(3):161–170, 2003
- Lock M: *Encounters With Aging: Mythologies of Menopause in Japan and North America*. Berkeley, University of California Press, 1993
- Lu FG, Lim RF, Mezzich JE: Issues in the assessment and diagnosis of culturally diverse individuals, in *American Psychiatric Press Review of Psychiatry*, Vol 14. Edited by Oldham JM, Riba MB. Washington, DC, American Psychiatric Press, 1995, pp 477–510
- Meyer C: *The Wandering Uterus: Politics and the Reproductive Rights of Women*. New York, New York University Press, 1997
- Mitchell B, Lovegreen L: The empty nest syndrome in midlife families: a multimethod exploration of parental gender differences and cultural dynamics. *J Fam Issues* 30(12):1651–1670, 2009
- National Institutes of Health: NIH Guidelines on the Inclusion of Women and Minorities as Subjects in Clinical Research—Amended, October 2001. Bethesda, MD, National Institutes of Health, 2001. Available at: http://grants.nih.gov/grants/funding/women_min/guidelines_amended_10_2001.htm. Accessed August 16, 2011.

- National Library of Medicine: Dr. Carol Cooperman Nadelson, in Changing the Face of Medicine: Celebrating America's Women Physicians. Bethesda, MD, National Library of Medicine, 2011. Available at: http://www.nlm.nih.gov/changingthefaceofmedicine/physicians/biography_233.html. Accessed August 13, 2011.
- Notman M, Nadelson C: Gender, development and psychopathology: a revised psychodynamic view, in Gender and Psychopathology. Edited by Seeman M. Washington, DC, American Psychiatric Association, 1995, pp 1–16
- Patel V: Where There Is No Psychiatrist: A Mental Health Care Manual. London, England, Gaskell (The Royal College of Psychiatrists), 2003
- Picard A: Are breast implants a form of mutilation? The Globe and Mail, January 16, 2012a. Available at: <http://www.theglobeandmail.com/life/health/new-health/andre-picard/are-breast-implants-a-form-of-mutilation/article2304457/>. Accessed January 23, 2012.
- Picard A: Sex selection is a complex issue with many nuances. The Globe and Mail, January 17, 2012b. Available at: <http://www.theglobeandmail.com/life/health/new-health/andre-picard/sex-selection-is-a-complex-issue-with-many-nuances/article2306066/>. Accessed January 23, 2012.
- Rodin M: The social construction of premenstrual syndrome. Soc Sci Med 35(1):49–56, 1992
- Seedat S, Scott KM, Angermeyer MC, et al: Cross-national associations between gender and mental disorders in the World Health Organization World Mental Health Surveys. Arch Gen Psychiatry 66(7):785–795, 2009
- Seeman M: Gender issues in psychiatry. Focus (Am Psychiatr Publ) 4(1):3–5, 2006
- Seeman MV, Lang M: The role of estrogens in schizophrenia gender differences. Schizophr Bull 16(2):185–194, 1990
- Sheppard M: Women are changing the face of medicine but are underrepresented in high-level positions. CBC News, March 7, 2011. Available at: <http://www.cbc.ca/news/health/story/2011/03/07/f-women-medicine-iwf.html>. Accessed August 13, 2011.
- Tseng W-S: Clinician's Guide to Cultural Psychiatry. San Diego, CA, Elsevier Science, 2003
- Vigod SN, Stewart DE: Emergent research in the cause of mental illness in women across the lifespan. Curr Opin Psychiatry 22(4):396–400, 2009
- Walsh C: Unraveling a brutal custom: foot binding in China tied to hand weaving, study finds. Harvard Gazette, December 9, 2011. Available at: <http://news.harvard.edu/gazette/story/2011/12/unraveling-a-brutal-custom/>. Accessed January 20, 2012.
- Wood J: Gendered Lives: Communication, Gender and Culture. Boston, MA, Wadsworth, Cengage Learning, 2010

World Health Organization: Women's Mental Health: An Evidence Based Review. Geneva, Switzerland, World Health Organization, 2000

World Health Organization: Women and Health: Today's Evidence, Tomorrow's Agenda. Geneva, Switzerland, World Health Organization, 2009

Sexual Orientation

Gay Men, Lesbians, and Bisexuals

Marshall Forstein, M.D.

Jason Lambrese, M.D.

Tauheed Zaman, M.D.

Lesbian, gay, and bisexual (LGB) individuals are diverse in terms of socioeconomic status, racial and ethnic identity, age, education, religious affiliations, income, and geographic residence. There is great variability in the degree to which sexual orientation is central to one's identity, and acceptance or rejection of stereotypes or association with other LGB people also varies widely among LGB individuals. Although defined by their sexual orientation, **LGB people are as diverse as the general population.** As with any minority individual, a single element of identity, such as sexual orientation, can often define the group, obscuring the complex nature of individual experiences and

the widely variable social experience. It is therefore difficult to talk about LGB people as belonging to a single “culture.” Differences within groups are often minimized when comparing differences between groups, leading to generalizations and stereotypes that reinforce prejudice and bias (Adams and Phillips 2009; Herdt 1996).

We use the term *LGB individuals* to include all men and women who have a predominant or significant same-sex orientation, including those who might not use the term LGB in referring to themselves. Self-labeling may vary greatly depending on the political, social, personal, and cultural implications of the terms for the individual.

In this chapter we focus on the developmental and intrapsychic processes and social experiences that are common to sexual minorities and the assessment of sexual identity and other salient features, such as their role in family and community systems. Viewing sexual minorities through the lens of cultural psychiatry requires an understanding that as a minority culture, there is great variability in the populations encompassed by the idea of “culture,” much as there is no single way to think of racial or ethnic “cultures” as uniform. Because sexual orientation is but a part of identity, many of the concerns presented in other chapters are more explicit about identity formed by gender, age, and racial/ethnic aspects of the individual’s experience of family and society (Dykes 2000).

Importantly, the use of the updated DSM-5 (American Psychiatric Association 2013) Outline for Cultural Formulation (OCF; see Appendix 1) and Glossary of Cultural Concepts of Distress (see Appendix 2) is framed to help clinicians to understand the role of culture in the expression of psychiatric disorders. Because homosexuality per se is *not* a pathological disorder, the usefulness of this section of DSM-5 is primarily in viewing individuals with same-sex orientation and sexual minorities through the cultural lens and in understanding how sexual orientation may be a factor in the individual’s manifestation of an underlying psychiatric disorder, especially in interpersonal relationships with health care providers and therapists.

LGB individuals have unique health care needs and often experience invisibility, ignorance, or overt prejudice in the current health care system. Our understanding of sexual minorities (who represent a relatively small percentage, estimated to be between 2% and 10% of the overall population) is largely based on clinical experience and, in most instances, a few large population sys-

tematic studies of specific medical and mental health needs. Medical, nursing, and other health care trainees are provided minimal education about sexuality in general and usually little or none about the approach to the assessment and treatment of sexual minorities, as well as their specific medical and mental health needs (Sanchez et al. 2006).

Although physicians in training often encounter same-sex orientation or bisexual individuals in clinical practice, little attention is paid to understanding the experience of sexual minorities in the health care system, family, or society. Without training and education about the spectrum of individuals who identify as a sexual minority, providers with even the best intentions often make assumptions and behave professionally, or unprofessionally, on the basis of a more stereotyped view of LGB people. For example, sexual minorities can be treated with disrespect, avoidance, and even overt hostility (Flores et al. 2000; Smith and Mathews 2007). Unlike individuals who present with an obvious ethnic or racial identity, the vast majority of sexual minorities would be invisible without self-disclosure to others.

The Institute of Medicine (2011) released a rather extensive report titled “The Health of Lesbian, Gay, Bisexual, and Transgender People” that outlined the conceptual perspectives used in reporting on the medical and mental health needs of sexual minorities. We use this framework for the discussion of LGB issues:

- The minority stress model calls attention to the chronic stress that sexual and gender minorities may experience as a result of their stigmatization.
- The life course perspective looks at how events at each stage of life influence subsequent stages.
- The intersectionality perspective examines an individual’s multiple identities and the ways in which they interact.
- The social ecology perspective emphasizes that individuals are surrounded by spheres of influence, including families, communities, and society.

In 2011, the Joint Commission released a report titled “Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual and Transgender (LGBT) Community: A Field Guide.” This guide set forth for all hospitals accredited by the Joint Commission expectations concerning the access to care and the quality of care for

sexual minorities. It is yet to be seen how this document will affect actual care for the LGBT population (Joint Commission 2011).

Most LGBT people will have heterosexual providers. Some providers may be LGBT but have not disclosed their sexual orientation to patients or anyone. Some LGBT physicians, nurses, and other health professionals are openly identified, but many may remain “closeted,” fearing rejection by colleagues or patients. Those in academia may also fear that they will be passed over for promotions or clinical advancement if they are “out” as lesbian, gay, or bisexual. It is not known how many LGBT-identified students decide against entering medicine or nursing out of concern for their identity being discovered or have had their medical career trajectories adversely affected.

More recently, many medical schools are developing nondiscrimination policies that include sexual orientation. Fewer include gender identity and expression. Some studies have shown reluctance of applicants to medical schools to disclose their same-sex or bisexual orientation (Merchant et al. 2005). Applying to residency programs or other postgraduate training may present further concerns for sexual minority physicians graduating from medical schools or graduate students out of fear that disclosure will affect their competitiveness for the most desirable positions (Oriel et al. 1996).

In order to ensure that sexual minorities have access to quality care, professional training and medical education must incorporate a culturally sensitive approach to working with LGBT patients in the health care setting. Health care providers can also improve the care of sexual minorities by working with schools, religious organizations, and social service agencies (including child, disability, and elder services) to educate and reduce the stigma associated with the interface of sexual orientation and gender with those institutions (Lena et al. 2002; Perrin et al. 2004). Public schools in California are required to include LGBT issues in their standard curriculum by Senate Bill 48, effective January 1, 2012, which adds LGBT issues to other minority group instruction that is already required. In many urban centers, the establishment of freestanding or health care system–based dedicated LGBT services has provided medical and psychosocial support for both the general and the unique problems of LGBT people (Liddle 1999).

Disclosure of Sexual Orientation to Providers

Several studies from the 1980s and 1990s suggested that a significant proportion of LGB patients did not disclose their sexual orientation to their primary care physicians. One British study reported that 44% of gay male patients in the study population did not disclose their homosexuality to their primary care physicians (Fitzpatrick et al. 1994).

Of African American lesbian and bisexual women, 45% did not disclose their sexual orientation to their physician (Cochran and Mays 1988). Overall, white gay-identified men were more likely to disclose sexual orientation to their physician, further supporting the concept that having a dual or triple minority status (e.g., black, female, and lesbian) increases the perception of risk in such disclosure. More current research is needed to understand how the increased visibility and social acceptance of sexual minorities may alter these findings (Klitzman and Greenberg 2002). Adolescents who have not consolidated a sense of their sexual orientation may not disclose to providers out of fear of rejection or disclosure to parents (Meckler et al. 2006).

For LGB patients to receive appropriate medical and mental health care, disclosure of sexual orientation is essential, and it is incumbent on clinicians to embrace learning about sexual as well as other cultural/racial minorities to obtain the background information needed to create a welcoming attitude and atmosphere (Jackson et al. 2008; Potter 2002).

Epidemiology of Homosexuality

There have been many studies to determine the epidemiology of homosexuality in the United States, but these studies have been problematic for several reasons. Studies have varied in their definition of homosexuality and how people respond to the specific terms used in a particular study, leading to inconclusive evidence (Michaels 1996). In ethnic and racial minority communities, men who have sex with men do not necessarily self-identify as “gay,” an aspect of culture that was addressed in the early 1980s by the Centers for Disease Control and Prevention with the advent of the AIDS epidemic in order to capture all of the men at risk from unprotected same-sex behavior. This change in nomenclature was essential in understanding the cultural and racial

aspects of sexual orientation and behavior. Even in a more tolerant and accepting society over the past decade, many individuals are reluctant to admit to being LGB for the realistic fear that such disclosure may be damaging to them (Seal et al. 2000). Furthermore, during childhood and adolescence, when many aspects of identity within the family and society are being formed, there is great variation in the degree to which any individual might be conscious of his or her same-sex orientation.

Kinsey's studies are cited as showing a lifetime population prevalence of homosexuality of around 10% (Kinsey and Pomeroy 1948, 1954). Additionally, his work contributed to our understanding of the multidimensional nature of sexual orientation. Scaling heterosexual and homosexual experiences from 0 to 6, ranging from exclusively heterosexual to exclusively homosexual, he found that a sizable minority had both homosexual and heterosexual experiences, and a small minority was exclusively homosexual. However, his study population was nonrandom, and the studies relied on only sexual behavior as the criterion for sexual orientation.

The National Health and Social Life Survey in 1992 used a multidimensional framework that included behavior, desire, and identification (Laumann and Gagnon 1994). This study purported that 10% of men and 5% of women had homosexual contact since puberty, and 5% of men and 4% of women had homosexual contact since age 18 years. Although these data are also questionable because of the sampling methods, they are consistent with findings that sexual orientation is not bifurcated simply into homosexual and heterosexual orientation. Kinsey and Pomeroy (1948) stated:

Males do not represent two discrete populations, heterosexual and homosexual. The world is not to be divided into sheep and goats. It is a fundamental of taxonomy that nature rarely deals with discrete categories. . . . The living world is a continuum in each and every one of its aspects. . . . While emphasizing the continuity of the gradations between exclusively heterosexual and exclusively homosexual histories, it has seemed desirable to develop some sort of classification which could be based on the relative amounts of heterosexual and homosexual experience or response in each history. (p. 639)

A study of more than 6,300 British women ages 16–44 that used face-to-face interviews and computer-assisted self-interviewing from 1999 to 2001 re-

ported the prevalence of women who had sex with women to be 4.9% (Mercer et al. 2007). As evidenced by the extant studies, less is known about the issues facing LGB people who are members of racial or ethnic minorities or are elderly. Most of the attention has been on the majority population in the United States between ages 16 and 50. Recent studies of HIV seroconversion, however, indicate that most young black and Latino males who identify as men who have sex with men and those age 50 and older account for a significant number of new infections. More research is needed to address the specific medical and mental health needs of dually identified sexual minorities and the elderly (see section “Dual Minority Identity” later in this chapter). The increased risk for HIV infection in young men who are emerging into their sexuality proves the need for continued education and interventions for this population. The assumption of HIV infection as a young, “gay” disease belies the actual risk of sexual activity in those older than 50.

The actual percentage of the population who might be categorized as a sexual minority will continue to be debated and studied, but it is clear that a distinct minority of people are same-sex oriented in a variety of ways. Clinicians are therefore required to know how to assess sexual orientation and to understand the role of sexual orientation in a particular person’s life and the developmental issues and social realities of being a sexual minority in a heterosexually dominant culture. Clinicians must appreciate the experience of LGB people within the health care system, with its overt or covert antihomosexual bias. Medical forms most often are not proactively welcoming, with no recognition of same-sex relationships. LGB parents often have to change information on forms that assume a two-gender parental relationship, creating bad feelings such as anger, disappointment, and resentment at again not being included.

Clinicians working with LGB people may assume that they are comfortable with sexual minorities in their care. However, a British study in 1989 reported that only 32.7% felt comfortable with gay men, 40.8% believed gay men should not work in schools, and 11.4% thought that homosexuality was an illness (Bhugra 1989).

Becoming more comfortable working with people who are different from oneself occurs with clinical experience and safe, nonjudgmental supervision. As with racial/ethnic or religious prejudices, to become more comfortable

working with LGB patients requires first acknowledging the negative assumptions or biases that are present in society and often the families we come from before moving through to a more positive acceptance of difference in others and ourselves.

The following vignette is an example.

Case 1

A white, Jewish, heterosexual male psychiatry resident was working in therapy with a graduate student from a Muslim country who divulged after several months of therapy that he had fantasies and some sexual experiences with men. The patient made a point of noting that he was glad to have a white, Jewish doctor who was gay himself because no heterosexual male, especially from his own religion or culture, would ever be treating him with such respect.

The patient was presented in a group seminar on sexuality during the sessions on transference and countertransference. The seminar leader (author M.F.) and one resident in the group were gay. With disclosure of more information, the presenting resident was able to acknowledge how he had felt very uncomfortable with the presumption on the part of the patient that he must be gay too and how he had had to fight an instinct to disclose that in fact he was heterosexual. The gay resident in the group and the seminar leader supported the presenting resident by acknowledging how hard it is to be assumed to be something one is not, and unlike race or gender, sexual orientation is often invisible. The seminar leader affirmed the great wisdom of the resident in not disclosing but rather using the assumption to explore the internalized homophobia of the patient. The resident himself was able to understand in a very visceral way the feeling of being judged by even the assumption of being gay. The gay resident was able to discuss the process of growing up and wanting to be heterosexual for a part of his adolescence, acknowledging his own journey through internalized homophobia, and how working through that to a point of self-acceptance required the nonjudgmental acceptance of peers and family after he came out.

This case illustrates that patients may hold significant assumptions, in this case that **the resident must be gay because no heterosexual** (i.e., “normal”) therapist would like or really care about him, a projection perhaps based on his assumption that his father or men in his culture would reject and in fact harm him. It may also represent an erotic transference toward the therapist on the part of the patient, who might also want the therapist to be attracted to him.

Psychiatric Disorders and Suicide in Lesbian, Gay, and Bisexual People

Although same-sex orientation is not per se a mental disorder, research indicates that compared with their heterosexual counterparts, gay men, lesbians, and bisexuals may be at elevated risk for psychological and substance use morbidity, including higher lifetime incidence of histories of suicide attempts (Burgard et al. 2005; Marshal et al. 2011; Mustanski et al. 2010). The increased vulnerability has been described in several studies to be largely a result of a stress model of development rather than intrinsic factors in LGB people (Cox et al. 2011; Mays and Cochran 2001; Meyer 2005). Discrimination, and in particular homonegativity and more virulent homophobia, may compound the experience of dual-identity sexual minorities.

Although many studies suggest that as a group, LGB people have higher rates of mental disorders and suicidal ideation and attempts, it is difficult to separate to what degree the increased vulnerability is due to stigma and discrimination. Some studies even suggest that the perception of discrimination by LGB adolescents may contribute to depression and hopelessness (Almeida et al. 2009).

A nationally representative sample in Canada suggested that lesbian and bisexual women had a threefold increase in substance use disorders compared with their heterosexual counterparts, and gay men had twice the rate of anxiety and psychotic disorders. Suicide rates were independently associated with bisexuality at three times the odds ratio of heterosexuals (Bagley and Tremblay 2000; Bolton and Sareen 2011).

Although racial/ethnic minority groups generally have a lower lifetime prevalence of mental disorders than do whites, which is a risk factor for suicide attempts, one study reported higher rates of suicide in racial/ethnic sexual minorities, which was not explained by higher rates of depression or substance use (O'Donnell et al. 2011).

For Asian American and Latino LGB individuals, dual minority identity is thought to increase vulnerability to the adverse mental health effect of discrimination and marginalization. In a study of Asian Americans and Latinos (Cochran et al. 2007), gay and bisexually classified men were significantly more likely than heterosexually classified men to report a recent history of a

suicide attempt. Gay and bisexually classified women showed the same trend, although the findings did not reach statistical significance.

Lesbian and bisexual women were more likely than heterosexual women to report depressive disorders, both lifetime episodes and in the past year. They were also more likely to have positive recent histories of substance use disorders. Gay or bisexual men, however, were less likely than heterosexually classified men to meet criteria for recent substance dependence or abuse (Cochran et al. 2007). A meta-analysis by King et al. (2008) attempted to examine the prevalence of mental disorder, substance use issues, suicidal ideation, suicide attempts, and deliberate self-harm in LGB individuals in comparison with the prevalence in the general public. Their analysis, with the applied rigorous criteria guided by the quality measures in the *Cochrane Handbook for Systematic Reviews of Interventions* (Higgins and Green 2011), extracted data from 214,344 heterosexual and 11,971 LGB individuals. King and colleagues reported a sobering twofold increase in prevalence of lifetime suicide attempts by LGB persons, with a pooled risk ratio of 2.47 (confidence interval=1.87, 3.28). In terms of particular disorders, the team reported at least a 1.5 times increased risk for depression and anxiety disorders (relative risk [RR]=1.54–2.58), as well as a similarly increased risk for alcohol and other substance dependence (RR=1.51–4.00). In comparing different demographics within the LGB population, the investigators reported an increased risk of substance dependence among lesbian and bisexual women and an increased prevalence of suicide among gay or bisexual men. In interpreting the results of their analysis, King et al. stated that “it is likely that the social hostility, stigma, and discrimination that most LGB people experience is at least part of the reason for the higher rates of psychological morbidity observed.... [N]ational suicide strategies need to include LGB people as a high risk group now rather than await more evidence on suicide.” On an individual level, psychiatrists’ appreciation of this heightened risk may prove a significant asset and protective factor for their LGB patients (King et al. 2008).

Some limitations of the currently available research include methods for identifying the research sample and the inconsistent definitions of who identifies as gay, lesbian, or bisexual across studies. Any increased individual risk for a psychological or substance use disorder may be only partly accounted for by sexual orientation itself rather than by a complex matrix of variables that include age at “coming out,” support within families of origin, the sense of be-

longing to a community, experience of prejudice and discrimination, and heritable biological factors. During an assessment, the clinician can ask the patient to create a narrative about his or her individual experience as a single or dual minority by thoughtful questioning. Other factors, such as HIV status or other medical concerns, must be considered as well (Fergusson et al. 1999; Lock and Steiner 1999; Russell and Joyner 2001). Concerns about increased rates of suicide in the LGB population have been well documented in the literature (Haas et al. 2011; Herrell et al. 1999; Remafedi 1999).

History of Homosexuality

As with any minority population, history is relevant to the dynamic and social issues that currently confront LGB people. Having an African American president of the United States does not mitigate the legacy of racism in America, nor can the legacy of how homosexual individuals have been treated throughout history, including by the medical field (particularly during the early twentieth century with the theory and practice of psychoanalysis), be assumed to be only historical. Often, an oppressed group, such as homosexuals, incorporates its history into the internal belief systems about what it means to be and to live as a same-sex-oriented person. Even in states where gay marriage is now legal, antihomosexual bias and the dominant heterosexism of society affect young people discovering their sexual orientation while they undergo developmental processes that are critical to their integration of sexual identity into an authentic self. The history of homosexuality presented in this chapter describes the interface of science, theory, culture, religion, politics, and medicine as it informs social structures and psychological perspectives. The history of society's response to acknowledging same-sex behavior is often relevant to the internalized belief system with which individuals have grown up.

Unlike other visible minority cultures, sexual minorities are often uninformed about the history and the effect that attitudes and stigma have had on how people have lived and dealt with stigmatized and rejected identities. The lack of intergenerational social relationships among most LGB people further engenders a sense of isolation and perpetuates the fears and anxieties of being visible. Although no single "culture" of LGB identity exists, the themes related to the marginalization of sexual minorities and the institutionalization of anti-LGB attitudes cross lines of ethnicity, gender, and historical periods. Learning

about the history of sexual minorities can provide a historical context in which individuals may feel less isolated and unique.

The concept of a discrete LGB identity and “culture” is new, but the reality of human same-sex behavior can be traced back to antiquity and is found ubiquitously throughout the animal species (Roselli and Stormshak 2009; Vasey and Jiskoot 2010; Vasey and Pfaus 2005).

Antiquity

Accounts of same-sex love and sex can be found in writings from classical antiquity in the works of Herodotus, Plato, Athenaeus, Xenophon, Sappho, and others. The actual sexual behavior, active (dominant or penetrative) or passive (submissive), was the basis for relationships rather than a notion of a sexual orientation or identity. Plato, in his dialogue *Symposium*, suggested that the best army would be made up of male lovers. A dominant role (inserted) was associated with masculinity, higher social status, and adulthood, whereas the passive role (penetrated) was associated with femininity, lower social status, and youth. In ancient Greece, originating in the tribal period before the establishment of the city-states, *pederasty* was the term given to the role of older, more established men who would play the roles of mentor, educator, instructor, and sexual penetrator. Pederasty was incorporated into the social structure as a social institution—a relationship between an adult man and boys between age 12 and age 17, at which point the boy became a man. Sappho, an Ancient Greek poet, is regarded as one of the first women to write love poems to women, and her poetry is regarded as emblematic of the love between women. She was born on the island of Lesbos, the origin of the word *lesbian* (Faderman 1981).

Middle Ages

In the eleventh century, the Biblical tale of Sodom and Gomorrah was used by Saint Peter Damian to refer to any form of biblically condemned sexual activity (fornication, masturbation, oral or anal sex) regardless of the gender of the participants. *Buggery* referred to anal sex between men. During the Middle Ages, the ecclesiastical courts were charged with trying cases of sodomy pursued when antichurch activity was suspected. There was a sharp rise in the intolerance of homosexual behavior in the twelfth through fourteenth centuries, corresponding to the intolerance and persecution of Jews, Muslims, and her-

etics. The Catholic Church proposed that any sexual behavior outside of marriage was nonprocreative and was hence “unnatural” and morally wrong. *Sodomy* meant behavior, not personhood. Thus, one could not be called a sodomite unless one was engaging in such behavior. Even heterosexual individuals who engaged in “sodomy” (anal sex) would be punished, unless, of course, one repented of one’s “sin” and vowed never to do it again. Even though intolerance was not based on the gender of those involved, some theologians singled out same-sex sodomy as the worst sexual crime against nature (Boswell 1980).

Religious prohibitions against homosexuality based on the Old Testament in the Middle Ages gave way to the development of secular laws. In 1533, England enacted the first secular law criminalizing buggery, which was punishable by hanging. As part of King Henry VIII’s campaign against the Catholic Church, he established the Buggery Act, adopted by the English colonies in America. Over the next several centuries, many people were put to death, and same-sex sexual behavior remained a crime often punished variably by reasons of class and power rather than some equal administration of the law. Religious prohibitions against same-sex sexual behavior (nonprocreative) remain punishable by death in several countries (Siker 2007).

“Age of Enlightenment”

When Napoleon came to power, he initiated the Napoleonic Code, which decriminalized same-sex sexual behavior, although in many countries it remained a crime. Sodomy was no longer a capital crime punishable by death. In the eighteenth and nineteenth centuries, an overtly theological framework about homosexuality was replaced by secular discourse and theory. Medical doctors were asked to evaluate sex crime defendants, leading to the medicalization of sexuality.

Much of the medical theory surrounding homosexuality in the nineteenth century stemmed from legal cases surrounding sexual behavior. Theorists struggled with the question of whether those accused of sexually deviant behavior could be held accountable in court if these activities stemmed from a mental illness. The stage was then set for the parallel and inextricably linked evolutions of the medical and legal perspectives on homosexuality. Over the following century, both fields would struggle with the question of pathology and criminality, borrowing heavily at times from each other’s latest theories on

the topic and at times acting in opposition to the other's established norms. Of note is that the term *homosexuality* itself did not enter common use until later in the nineteenth century.

Even in the midst of the considerable social stigma surrounding homosexuality in the early to mid nineteenth century, several prominent figures championed the rights of homosexual individuals. Karl Heinrich Ulrichs (1825–1895) argued against Germany's efforts to criminalize sodomy. He argued that homosexuality represented a hereditary medical condition, and therefore courts could not criminalize sodomy as an immoral act. His writings furthered the theory that *Urnings* were something of a third sex—a man's body with a woman's constitution. Even as Ulrichs furthered this seemingly biological notion of homosexuality, his writings continued to touch on the legal forces homosexual persons found themselves subjected to during his era. He said, "The legal institution of marriage is not the institution for us. . . . [T]he natural state of the species exists for us, as it does for birds in the sky and animals in the field" (Ulrichs 1862/1994, p. 40). This quotation both expresses his opinion on the natural state of homosexuality and foreshadows with surprising clarity the future (and for us, current) controversies surrounding the civil rights of LGB people.

Other European writers and activists built on Ulrichs's work to effect changes in the legal system on the basis of medical theories of homosexuality. Karl Maria Kertbeny (1824–1882) first used the term *homosexual* in a similar resistance to Germany's sodomy laws. A physician finally entered the fray as well, in the form of Karl Westphal (1833–1890), who published cases based on both men and women who were attracted to the same sex. He termed this condition *contrary sexual sensation* and argued that these individuals deserved psychiatric care rather than criminal punishment (Westphal 1869).

Medicalization of Homosexuality

Westphal's diagnosis would undergo a series of linguistic transformations as experts translated his works into their respective native tongues. For the renowned neurologist Jean-Martin Charcot (1825–1893), the term became *inversion of the genital sense* in French, and he described homosexuality as a degenerative condition and serious mental illness (Charcot and Mangnon 1882). Yet another forensic writer and German, Richard von Krafft-Ebing

(1840–1902), continued the thread of Westphal's work, publishing the *Psychopathia Sexualis* in 1886 (Kraft-Ebbing 1894). This book contained some of the key terms that would become the *lingua franca* for theorists in the field: *homosexuality* (popularizing the term coined by Kertbeny), *sadism*, and *masochism* among them. The term *sexual inversion* also became a part of the lexicon when sexologist Havelock Ellis (1859–1939) and his homosexual collaborator John Addington Symonds (1840–1893) published a book of the same title (Ellis and Symonds 1897/1975).

Sexologist Magnus Hirschfield (1868–1935), a known homosexual physician, argued that homosexuals were a natural variant in the spectrum between maleness and femaleness. Hirschfield also composed some of the seminal texts on transvestism and transsexuality. These concepts emerged later with the conflation of orientation, gender identity, and gender role, including presumptions about receptive or insertive sexual behavior, masculine and feminine personality structure, and behavior or vocational interests. The historical social expectation that homosexual men were more female than male is evidenced in the public's preoccupation with über male athletes who come out as gay, which refutes this belief. These beliefs often feed into the denial of one's same-sex orientation when ethnic cultures place such value on masculinity and heterosexuality.

Freud and the Ascendancy of Psychoanalytic Theory

No discussion of psychoanalysis and sexuality would be complete without an examination of Dr. Sigmund Freud's work, which offered several theories on homosexuality during the early twentieth century. He argued that homosexuality could arise out of *oedipal conflict* and *castration anxiety*, overidentification with a mother, or reversion to anal eroticism, or as a *reaction formation* to jealousy of fathers and brothers that might be transmuted into love toward other men. Although his views evolved during his career, he remained resolute that an arrest in sexual development led to the condition. He argued against attempts to "cure" homosexuality, however, saying, "Homosexuality is assuredly no advantage, but it is nothing to be ashamed of, no vice, no degradation; it cannot be classified as an illness; we consider it to be a variation of the sexual function" (Freud 1951, p. 787; www.aglp.org/gap).

However, others believed that homosexuality was pathological. In his paper "A Critical Examination of the Concept of Bisexuality," Sandor Rado (1940/

1965) argued directly against Freud's theories and claimed that homosexuality was a direct result of phobic avoidance of the opposite sex and that this stemmed from parental control of childhood sexuality. Rado (1940/1965) believed, and led many analysts of his time to believe, that homosexuality could be "cured" because it stemmed from pathological upbringing. Dr. Bieber and colleagues (1962), who wrote *Homosexuality: A Psychoanalytic Study*, furthered this perspective. In this work, they profiled the stereotypical family dynamic that presumably produced homosexuals: a distant father and a domineering mother. He and his colleagues also claimed a 27% cure rate of homosexual subjects in his study. The stage was now set for many of the attempts to "cure" homosexuality that continue to find supporters in portions of the United States and many parts of the world today (Bieber et al. 1962). Socarides (1978) and others continued to promote a psychosexual arrested development theory that homosexuality can be "cured" by treatment. The continued purveyance of treatments today that promise to change sexual orientation feeds into the internal self-loathing and moral conflicts with which many LGB people grow up. The ethics and scientific legitimacy of "reparative therapy" have been discussed in the psychiatric literature (Shildlo et al. 2001; Stein 1996). Professional organizations such as the American Psychiatric Association (APA), the American Medical Association, the American Psychological Association, the National Association of Social Workers (NASW), the American Academy of Pediatrics (AAP), and the American Academy of Child and Adolescent Psychiatry (AACAP) do not support the research claiming to change sexual orientation. The American Psychoanalytic Association has also modernized its theoretical framework for thinking about sexual orientation (Lewes 1989; Magee and Miller 1996).

Alfred Kinsey and his colleagues led the countercurrent movement to see homosexuality as a normal variant. Their studies challenged the heterosexual/homosexual dichotomies as described by scientists in the 1940s and 1950s. The famous Kinsey scale, which ranges from 0 (exclusively heterosexual) to 6 (exclusively homosexual), provided a direct challenge to previous theories. This viewpoint argued for an open-minded approach to sexuality and an acknowledgment of its fluidity in most people. The acknowledgment that sexual orientation may be more on a continuum, at least for some, also has contributed to the need for greater clarity in studying who identifies as LGB (Kinsey and Pomeroy 1954).

Homosexuality and Modern Psychiatry

The evolution of the DSM definitions of homosexuality mirrored the conflicting views of analysts in the field. In 1952, the first DSM (American Psychiatric Association 1952) included homosexuality as a pathological condition, a “sociopathic disturbance” under the category of personality disturbances. In DSM-II (American Psychiatric Association 1968), homosexuality remained a sexual deviation, but it was separated from personality disturbances. That year, however, marked one of the seminal events in the struggle for gay and lesbian civil rights in the United States: the Stonewall Riots of New York City. When police carried out a then-standard raid on June 28, 1969, on the Stonewall Inn, the incident became one of the first documented incidents in which members of the gay and lesbian community publicly confronted and resisted the government’s persecutory policies. The initial face-off between gay, lesbian, and transgender patrons at the Stonewall Inn eventually led to the formation of multiple social and political action groups in New York City, and these groups sparked a movement for basic civil rights throughout the country. LGB communities throughout the United States and abroad continue to commemorate the Stonewall Riots during annual Gay Pride celebrations.

Just as activists pushed for LGB civil rights elsewhere in society, they pushed the APA to revise its definitions of homosexuality (Bayer 1987; Krajeski 1996) because the accepted definition of homosexuality as a mental disorder left LGB persons vulnerable to many of society’s homophobic prejudices and policies. Between 1970 and 1972, activists lobbied the APA to reconsider the definition during its annual meetings. Despite considerable internal controversy, the APA Task Force on Nomenclature and Statistics agreed to hear activists’ scientific arguments against pathologizing homosexuality. The task force further studied the evidence and eventually proposed that homosexuality be removed from DSM altogether. Other components of the APA ratified this position, and the official associations of psychologists and social workers soon followed the APA’s example. The APA went so far as to publish an official statement in support of civil rights for homosexuals. DSM-III (American Psychiatric Association 1980), which initially included “ego-dystonic homosexuality” as a disorder, was revised in 1987 to DSM-III-R (American Psychiatric Association 1987) to remove the term altogether. Both gay and lesbian psychiatrists and allies within the APA played a major

role in this paradigm shift away from pathology, and future versions of DSM continued to exclude homosexuality as a diagnosis (American Psychiatric Association 2000; Silverstein 1996).

The APA produced several statements in support of LGB civil rights in various spheres of society during the late 1980s and 1990s. The APA argued against workplace discrimination, exclusion and dismissal from the armed forces, sodomy laws, and continued attempts to “cure” homosexuality. The World Health Organization followed suit in 1992, removing the term *homosexuality* from ICD-10 in 1992. Wading into the more modern political fray, the APA has maintained its progressive standpoint on the issue, stating its support for legal recognition of same-sex unions in 2000, supporting adoption by same-sex couples in 2002, and supporting the rights of LGB persons to enter same-sex civil marriage in 2005. Other professional associations, including the American Psychological Association, the NASW, the AACAP, and the AAP, have also supported and affirmed the rights of LGB people to marry and parent.

The intertwined trajectories of legal and psychiatric perspectives on homosexuality remain evident today. Certainly, the APA’s use of scientific evidence to offer official positions on hot-button social and legal issues emphasizes this connection. Various LGB communities within the United States continue to struggle for civil rights on various fronts.

The rescinding of the military policy of “Don’t Ask, Don’t Tell” in 2010 allows LGB people to serve their country but also on a national level increases the acknowledgment that LGB people deserve the same basic rights as heterosexual people. Same-sex relationships are slowly being recognized in the United States and throughout the world (Table 8–1; for the most recent data, see <http://gregstolldyndns.org/marriagemap/>). In 2013, the U.S Supreme Court found the federal Defense of Marriage Act (DOMA) to be unconstitutional, opening the way for many court challenges to state laws banning same-sex marriage.

With the increasing visibility and acceptance of LGB people, “clinics” that promise cures for homosexuality have gained national attention, and organizations such as the National Association for Research Therapy of Homosexuality (NARTH) raise the specter of a pathological view of the LGB community. Politicians continue to use sexual orientation as an issue, and as a result, Congress is lagging behind the population in accepting LGB people as deserving of equal rights.

Table 8–1. Where same-sex relationships are legal

Location	Same-sex marriage	Civil unions/domestic partnerships
Vermont	2009	1999
Massachusetts	2004	
New Jersey	2011	2007
Connecticut	2008	2005
Oregon	2014	2008
Wisconsin	Banned in 2006	2009
Iowa	2009	
New Hampshire	2010	2008
District of Columbia	2009	
New York State	2011	
Maryland	2012	
Rhode Island	2013	2012
Washington	2012	
Maine	2012	
Illinois	2014	2012
California	2013	
New Mexico	2013	
Delaware	2013	
Hawaii	2013	
Minnesota	2013	
Pennsylvania	2014	
Argentina	2010	
Belgium	2003	
Canada	2005	
The Netherlands	2001	1998

Table 8–1. Where same-sex relationships are legal (*continued*)

Location	Same-sex marriage	Civil unions/domestic partnerships
Norway	2009	1993
Sweden	2009	1995
Spain	2005	
South Africa	2003	1999
Mexico	2010 (Mexico City)	2007 (Mexico)
Portugal	2010	2001
United Kingdom		2005 (equivalent to marriage)
Hungary		2007
Ireland		2009 (most rights/privileges)

Note. Because the status of same-sex marriage continues to change, see also the interactive updated same-sex marriage map available at <http://gregstoll.dyndns.org/marriagemap/>.

Source. Pew Forum on Religion and Public Life 2009; <http://gaymarriage.procon.org/view.resource.php?resourceID=004857>.

Given this history, it is not surprising that LGB individuals remain reluctant to come out as homosexual, with significant prejudice against them.

Sexual Identity Terminology

The development of a sexual identity begins at birth and is determined by a complex interplay of biological, psychological, social, cultural, and religious factors. Sexual identity consists of several components:

1. *Chromosomal identity*: XY, XX, or some variant (e.g., XXY, XYY)
2. *Anatomical expression of the chromosomal assignment*: male versus female primary and secondary characteristics and, infrequently, intersex anomalies
3. *Self-identification as “boy” or “girl”* (by age 2.5 years): usually consistent with the chromosomal and anatomical expression

4. *Sexual orientation*: a predominant erotic interest in either the same or the opposite sex, with most individuals identifying as heterosexual

Children who believe that they are of a gender at variance with their anatomy historically have been thought of as psychotic, but more recent studies suggest that some of these children will later identify as either same-sex oriented or transgender. Much of the dysphoria associated with these children derives from parental and societal reactions to the variant gender identity. (Transgender individuals are in a separate category and are not solely a variant of sexual orientation. For a discussion of transgender persons, see Chapter 9, “Transgender and Gender Nonconforming Patients.”)

Sexual orientation is based on deeply held conscious and unconscious psychological constructs and may manifest as behavior, desire, or fantasy. The etiology of sexual orientation thus far has not been conclusively shown to be either all nature or all nurture (Blanchard 2001; Byne 2007; Kirkpatrick et al. 2000).

Cultural Identity of the Individual: Development of a Lesbian, Gay, or Bisexual Identity

When using the DSM-5 OCF to evaluate sexual minorities, the first part the clinician completes is the “Cultural Identity of the Individual,” so a discussion of the development of an LGB identity is appropriate. One’s sexual orientation can be described on a variety of axes, including *feelings*, *behaviors*, and a *self-identified label*. A person can develop erotic, emotional, or sexual feelings toward members of the same sex, but it is important to recognize that the presence of these feelings does not necessarily indicate a specific identity label nor does their presence always lead to acting on those feelings. Separate from feelings are behaviors, in which a person engages in an emotional or a sexual relationship with a member of the same sex. Again, this does not necessarily mean that the person uses or will use an identity label consistent with *homosexual*. Finally, a person can adopt an identity label (such as gay, lesbian, bisexual, straight, or queer) to describe his or her feelings, behaviors, or both. The *identity label* is a socially constructed term that is based on societal expectations. The clinician must explore all aspects of the patient’s sexual orientation (feelings, behaviors, identity labels) because they can influence one another in many ways (Rosario et al. 2006).

Assessment of the complex multidimensionality of a person’s sexual orientation becomes important both clinically and in research. When we ask, “What is someone’s sexual orientation?” which dimension are we assessing? In the research literature, sexual orientation has been assessed in various ways, including asking the participant to self-identify with an identity label, asking for feelings of attraction to members of the same sex, or assessing for same-sex sexual contact. The variety of methods can make it difficult to compare results of studies that assess for sexual orientation in different ways. Clinicians must recognize that each person can have a mixture of identity, feelings, and behavior, depending on which part of the identity or developmental schema the individual fits into (e.g., a person could identify as heterosexual but feel attracted to members of the same sex despite not having had same-sex sexual contact). Similarly, not everyone with same-sex behaviors develops a homosexual identity.

Fritz Klein (1993) expanded on the Kinsey one-dimensional scale by creating a more complex grid that explores several different dimensions of how individuals think about their sexual, social, and psychological orientation over time (Table 8–2).

Table 8–2. Dimensions of sexual, social, and psychological orientation

Variable	Past	Present	Ideal
Sexual attraction			
Sexual behavior			
Sexual fantasies			
Emotional preference			
Social preference			
Self-identification			
Hetero/gay lifestyle			

Source. Adapted from <http://www.americaninstituteofbisexuality.org/thekleingrid/>.

Klein's sexual orientation grid addresses the complex aspects of sexual identity. The consistency of these dimensions across time suggests the degree of integration and consolidation of identity and also provides a view of the nature of relationships and attachments that an individual may have that provide support, resiliency, and affirmation. Heterosexual men may, for example, be heterosexually identified but be more homosocial in actual behavior, as in preferentially going out with male friends during the young adult years. Likewise, a lesbian may be homosexual but prefer the company of men with whom she might share a vocation or an interest in athletics. What Klein offers in this model is the need to avoid stereotyping sexual orientation with a particular set of behaviors or relationships. Clinically, it is helpful to think about the formation and internal development of a concept of self and self-in-relation as a developmental process and not an event (Klein 1993).

Although there is a theoretical basis, supported by clinical experience, that the alignment of self-image, fantasy, desires, behavior, and identity often leads to a greater sense of identity integration, the clinician needs to remember that these observations, and subsequent theoretical assumptions, derive from people often seeking help as a consequence of a conflict between how one feels and thinks about oneself and one's comfort in expressing that in the world. A more complex formulation incorporating the significant *barriers* to full identity integration must include the effect of important attachments and goals of the individual that might require a compromise formation in which that complete alignment is not reasonably possible. Many factors, including religious, cultural, individual personality, and interpersonal dynamics, affect the integration of all aspects of sexual identity. As mentioned earlier, the use of the DSM-5 OCF framework can be helpful in delineating the patient's cultural identity and how he or she interfaces with other parts of the community ("Psychosocial Stressors and Cultural Features of Vulnerability and Resilience"; formerly "Cultural Factors Related to Psychosocial Environment and Functioning—Stressors and Supports"; American Psychiatric Association 2000). Furthermore, the compromise formation that is psychologically and socially necessary at one phase of life may change during the life course. Thus, the model used in modern psychological theory based on a hierarchical system of healthy sexuality and identity is inadequate to describe homosexual identity development.

Various theorists have proposed models of sexual identity development that follow a similar developmental schema. Regardless of the developmental model, Troiden (1989) indicates that there are general principles that influence development, including the role of stigma; the developmental progression of assuming a sexual minority identity, including an increasing acceptance of a homosexual identity label during this process; the multistage model of development; and the role of contacts with members of the LGB community.

Troiden developed a similar four-stage developmental schema. His first stage, *sensitization*, begins in childhood and continues until puberty. At this point, individuals will begin to show what would later be labeled as gender nonconforming characteristics and experience marginalization from same-sex peers. If their sexual identity is questioned, they assume themselves to be heterosexual because the socially constructed identity labels do not mean much to them. Experiences in this stage are more gender based than sexuality based.

In the second stage, *identity confusion*, adolescents begin to associate their feelings and behaviors with the social construct of homosexuality. Confusion ensues as their previously assumed label of “heterosexual” conflicts with their feelings and behaviors, so they develop a self-perception of “probably homosexual” because of either their development of same-sex attractions or their lack of opposite-sex interest. They experience further stigma and are unable to discuss their confusion with others and will cope in a variety of ways: denial (“I am not homosexual”), repair (“I am going to try to be heterosexual”), avoidance (staying away from situations associated with homosexuality), redefining (“This is just a phase”), or acceptance (“I might be gay”). When working with patients at this stage, the clinician needs to assess the patient’s strategies for coping with stigma and begin to address the pertinent issues in psychotherapy. Young people beginning to acknowledge their same-sex orientation in the absence of external validation and affirmation may incorporate negative images of the self, often referred to as *internalized homophobia* (Allen and Oleson 1999). Although many people work through this in time, some retain this negative self-image and denial of self throughout their lives.

Internalized homophobic content becomes an aspect of the ego, functioning as both an unconscious introject and a conscious system of attitudes and accompanying affects. As a component of the ego, it influences *identity formation, self-esteem, the elaboration of defenses, patterns of cognitions, psychological integrity, and object relations*. Homophobic incorporations also embellish

superego functioning and, in this way, contribute to a propensity for guilt and intropunitiveness among homosexual males (and females) [author addition]) (Malyon 1981–1982).

During late adolescence, in the *identity assumption* stage, individuals self-identify as homosexual, begin to accept this identity, regularly associate with other LGB individuals, engage in sexual encounters, and become involved in the LGB subculture. Troiden points out that this developmental stage occurs differently in males and females. Males tend to develop in this stage in the context of sexual involvement with other males. Females are more likely to progress through this stage in the context of emotional involvement with other females.

During the final stage, *commitment*, individuals adopt homosexuality as a way of life, develop self-acceptance and comfort with the homosexual role, and no longer wish to be heterosexual. Men are likely to engage in sexual experiences with a variety of partners before focusing attention on one, whereas women develop sexual experiences in the context of emotional relationships (Troiden 1989).

As sexual minorities (including musicians, artists, actors, politicians, and athletes) become increasingly visible to the public, both male and female adolescents may internalize more positive representations of themselves. It is yet to be seen if emotional or sexual discovery remains different by gender.

Another **useful framework for understanding homosexual identity** development was enumerated by Cass (1979) with six stages of sexual identity development (Table 8–3). The first stage, *identity confusion*, occurs when one notes that “there is something about my behavior that could be called homosexual,” which causes one to ask, “Does this mean that I am a homosexual?” During *identity comparison*, the second stage, adolescents and young adults experience feelings of alienation accompanied by a loss of heterosexual-associated plans and expectations, such as marriage and children. At this point, a **comparison of the costs and rewards of assuming a homosexual identity occurs. A positive self-image will develop only when there are low costs and high rewards.** If this occurs, the individuals move on to the third stage, *identity tolerance*. Adolescents and young adults will recognize that they have an **explanation for their feelings, so they shift their focus to their social, sexual, and emotional needs.** They consider disclosure of their homosexual identity but are faced with significant societal stigma. Cass (1979) highlights the im-

portance of developing positive contacts with LGB individuals in an effort to progress to the next stage, *identity acceptance*.

During this fourth stage, one will experience continued positive contact with LGB individuals, which will lead to the person disclosing his or her sexual orientation (coming out) to others, thus recognizing homosexuality as equally valid as heterosexuality. When the individual progresses into the fifth stage, *identity pride*, the LGB account of the self is preferred and valued over the heterosexual option, and thus the person becomes immersed in the LGB subculture. The final stage, *identity synthesis*, occurs when one develops **sufficient comfort with the self so that anger and alienation diminish**, an integrated sense of self develops, and self-esteem improves.

Cass's model of identity development is applicable in clinical practice in that it recognizes that *behavior and identity are not always the same*; therefore, clinicians should meet the patient at his or her current stage and focus on the issues pertinent to that developmental period. Additionally, Cass (1996) points out the importance of fostering positive contacts with LGB individuals, and clinicians can be instrumental in aiding in this process. During the assessment and formulation, the clinician can use one of Cass's descriptive labels to describe the patient's developmental stage.

Other theorists have proposed similar mechanisms for development of a sexual orientation. **Minton and McDonald (1983–1984) used ego psychology** and proposed a three-step model:

1. *Symbiotic/ego-centric* stage: the developing homosexual feelings do not yet have greater societal meanings
2. *Sociocentric* stage: feelings are noted to have larger societal implications, providing relief that one is not alone as well as distress due to stigma
3. *Universalistic* stage: identity is accepted despite negative societal attitudes (Cox et al. 2011)

Browning (1987) developed a lesbian-focused theoretical model in response to the previous schemas, many of which are based on experiences with predominantly male populations. She claimed that an important difference **for lesbians is a focus on the relational context**. This differs from other models in that the predominantly gay male-focused theories are within a separation-individuation context, whereas the lesbian-focused schema is within a tradi-

Table 8–3. Cass's six stages of sexual identity development

1. Identity confusion
2. Identity comparison
3. Identity tolerance
4. Identity acceptance: coming out
5. Identity pride
6. Identity synthesis

Source. Adapted from Cass 1979.

tional marriage context. These other models view women's capacity for relatedness as less differentiated, but Browning (1987) reframes this as a prominent, necessary, and positive feature of lesbian identity development.

It is important to recognize that these are all theoretical models that are subject to limitations, such as recall bias. In addition, although these models are presented as a linear developmental process, often the actual development of an identity is less clear-cut and is influenced by myriad environmental and psychosocial factors (Rosario et al. 2006).

Developmental Milestones in Identity Development

In addition to the developmental theories put forth, there has been research into attempting to identify the ages at which sexual minority individuals reach certain milestones. It has been determined through studies conducted with members of the LGB community that, on average, individuals first become aware of their same-sex attraction at 10–12 years old, have their first same-sex sexual encounter at 13–16 years old, and first disclose their sexual identity to another person at 16–17 years old. This lends support to the notion that LGB individuals first consider their same-sex attraction in preadolescence, which means that clinicians should be speaking with patients about sexuality concerns at a *younger age*, such as age 10, with the goal of providing support through most of their identity development to prevent or mitigate later struggles (Allen and Oleson 1999; Maguen et al. 2002).

The time at which sexual minority youths first disclose their sexual orientation, or *come out*, is a major developmental step in the synthesis of a homo-

sexual identity. Maguen et al. (2002) reported that LGB youths come out first to themselves, then to a friend, and last to a parent. At the time of their survey, 95% of LGB youths had come out to a friend, 84% to their mother, 67% to their father, and fewer than half (48%) to their physician (Waldner and Magruder 1999).

Other studies have shown that only 22%–35% of adolescents come out to their physician. Another study found that 66% of teenagers wanted to come out to their physician but chose not to. Teenagers cite various reasons for this lack of disclosure, including that the physician did not ask, a parent was in the room, or they were unsure of the confidentiality policy. Because youths overwhelmingly reported that they had hoped their physician would initiate a conversation about sexuality and sexual orientation and would have been open to discuss their concerns (Allen and Oleson 1999; Meckler et al. 2006), physicians who see adolescents should not be afraid to assess their sexual identity directly.

When LGB individuals come out during adolescence, it is an example of a person going through his or her primary self-identification developmental tasks. However, when an individual comes out in adulthood, the person is forced to reevaluate an already defined heterosexual identity and go through the developmental process again, which can lead to further psychological stress (Browning 1987).

As previously discussed, males typically come out in the context of sexual encounters, whereas females typically experience their initial sexual attractions, emotional attractions, or both, within the context of their relationship with a woman friend. Women are more likely to be aware of their emotional or erotic feelings for other women before acting on them (Rosario et al. 2006).

Case 2

Ms. J. is a 23-year-old Asian American woman whose parents had immigrated to the Midwest when she was 2 years old. Her parents remained very traditional and private and had protected her during her childhood and adolescence with limited permission to join in social activities with her peers. Academics came first, and only in high school did she begin to play sports, developing a keen interest in and talent for field hockey. She became very close to and developed a “crush” on one of her teammates, who was Caucasian and very strong, verbal, and unafraid to speak her mind. On an away trip for a national field hockey competition, the teammate came out to Ms. J., and they

fell into a sexual experience that shook up Ms. J. to the point that she became afraid to go to school and see this friend. Assuming her parents' traditional views on sex and marriage would lead to being rejected by them because of her growing awareness of her same-sex attraction, she developed a severe depression, was hospitalized, and started taking medication and undergoing psychotherapy. She left the hospital without disclosing her sexual orientation to anyone, lest her parents be told. However, in outpatient therapy, she felt comfortable revealing her orientation and slowly developed an increased sense of her self, deciding to still keep this part of herself from her parents.

Away from home at college, she found a community of lesbian-identified women and became less depressed. She eventually moved to the Bay Area, away from her parents, after college for "work," remaining secretive about her sexual orientation.

The above case shows that members of some minority groups may have more difficulty coming out to their parents because of traditional gender role expectations. Although much is written about the coming out process and development of a sexual minority identity, there are fewer studies that adequately describe the effect of growing older with an LGB identity. Each phase of the life cycle brings with it particular developmental issues that may be affected by sexual orientation (Kertzner 2001). Older LGB people have often experienced overt or covert discrimination earlier in their lives that continues to affect how they experience their sexuality later in life (Haber 2009). Furthermore, older LGB people may not have as much access to health care and social services and may be more reluctant to acknowledge their sexuality out of fear of discrimination.

Less is known about the actual prevalence rates of bisexuality in men (Coleman and Rosser 1996; Sandfort and Dodge 2008) and women. Although it is assumed that women are more likely to be fluid in their sexual orientation than men, no significant general population-based studies confirm or explicate bisexuality. There is little consistency in the use of the terms in assessing what is meant by bisexuality. Few studies distinguish between co-temporal experiences with both genders and sequential sexual relationships.

Gender nonconformity in adolescence also affects psychological health and the coming out process. Often, children with gender nonconformity are perceived as "sissies" or "butch" and are assumed to be same-sex oriented as well (Skidmore et al. 2006). Younger adolescents who are stigmatized as a sexual minority may vary from those who are gender conforming and are able to

proceed through identity formation tasks without the stigma of being alienated or ostracized by peers, thereby heading on a life course more approximating that of their heterosexual peers (Floyd and Bakeman 2006).

Coming Out Throughout the Life Cycle

Not all LGB people come out during adolescence. Many factors affect whether the individual can acknowledge even to himself or herself the sexual feelings and emotional longings for someone of the same sex. An individual may be totally inhibited sexually and repress any awareness of sexual longings toward either sex, whereas another may be aware of his or her same-sex attraction but for complex reasons is not ready to accept and embrace his or her sexuality or disclose this sexual orientation to self or others. It is not uncommon for some people to delay integrating suppressed or repressed sexual or affectional longings until later in life. Both men and women may choose to follow the heteronormative path and marry and have children before later identifying as LGB.

It is important to realize that in the United States, Western Europe, and a few other nations, there has been a seismic culture shift in attitudes and policies over the past 40 years. The experience of a young person coming out today will be quite different from the experience of many elders who grew up at a time when coming out was not visible or was perceived as an option with great risk and sacrifice involving marginalization, rejection, and stigmatization. Thus, even a model of coming out that may adequately address the process today may not be useful in the future. Just as interracial and interethnic marriage is changing existing notions of race and ethnicity, the culture of sexual minorities affects how we think about sexuality, gender roles, parenting, and love.

The development of a self-concept is a lifelong process. Many models of psychological development have been proposed, with more or less emphasis on what has been reduced to a schema of “nature versus nurture.” The infant begins with more biologically driven needs and learns about the self and the self in relation to varying degrees of psychological attachment between infant and parent(s). Influencing the subsequent process of maturation are genetic, embryological development; the intrauterine environment; neurological development; and psychosocial and sexual growth. Thus, when a particular per-

son is coming out, this process requires assembling many aspects of the self in order to move to a positive sense of belonging and being effective in the world.

Goffman (1963) examined the notion of the “spoiled identity,” making a distinction between those aspects of self that are discredited, such as color, age, and gender, and those that are discreditable, usually quite hidden, such as sexual feelings. At that time in history, sexual minorities were considered deviant, immoral, and/or pathological. Currently, with the greater visibility of sexual minorities throughout society, more and more young people are coming out and rejecting the notion of that previously held belief of the spoiled identity, moving toward a sense of authenticity and rightful entitlement to be in the world as equals. Yet these cultural shifts have not happened equally throughout the United States. Additionally, for those who also endure discrimination and stigma because of other attributes such as mental illness, ethnicity, and gender atypicality, the concept of a spoiled identity continues to offer a frame in which to understand the individual.

Those who identify earlier may need to grieve the loss of the heterosexual privilege and its accompanying access to social acceptance. Despite more recent options for LGB people to parent, the process may include grieving the assumption of parenthood with early same-sex identification, particularly in cultures in which having children is central to the ethnic identity. Those who proceed through the heteronormative sequence of marrying and having children before coming out may need to grieve the lost opportunities attributed to the sexuality of youth and young adulthood. Clinically, even those individuals who are distressed by a delayed coming out usually would not trade the experience of having their own children for those younger experiences.

Increasingly, younger LGB persons are growing up in a society (at least in the United States and many developed nations) where the possibilities of becoming a biological or an adoptive parent are more evident. This normalizing of the possibility of parenting for LGB people, although challenging, is changing the developmental framework in which young people are conceptualizing what it means to be a sexual minority. Furthermore, same-sex parenting is providing substantial evidence that parenting roles, attachment, and social development proceed in a variety of family constellations. Individuals and families in different racial and ethnic cultures are variably struggling to incorporate these cultural shifts toward sexual orientation and gender. Same-sex couples

are raising children from various racial and ethnic backgrounds, changing how we think about multiple identity formation.

The effect of the digital age (social networking and the omnipresence of information on and examples of LGB lives on the Internet) has increased the positive images of sexual minorities for young people throughout the world. Thus, young people adept at accessing social media and information on the Internet may internalize a positive self-concept.

Among older generations, the coming out process has proceeded variably. Many were acutely aware of their sexual orientation when they were young but were unable for a complex set of reasons to acknowledge that sexual proclivity and live authentically, which often led to significant psychological distress. Others had a repressed awareness and engaged in the world with an “as if” personality, pretending to be heterosexual. For some elderly men and women, only after the loss of a spouse and the raising of children do they even begin to accept and acknowledge their authentic sexuality.

Case 3

Cultural Identity of the Individual

Mr. M. and Mr. H. are in their early 60s. Both were married to women and were friends since their days in college together. They were inseparable in college, often to the exclusion of seriously dating women. When they did date women, it was usually as a foursome. Mr. M. is white and works as a graphic designer in an urban center. Mr. H. is African American and a physician.

Psychosocial Stressors and Cultural Features of Vulnerability and Resilience

Mr. M. and Mr. H. lived in different parts of the country yet maintained at least weekly contact during their married lives, often vacationing together with wives and children. Mr. M., whose wife developed early-onset dementia and was in a nursing facility, leaned on Mr. H. for support emotionally to deal with the guilt that he could no longer care for his wife at home. Within the next year, Mr. H.'s wife died suddenly of a heart attack. The mutual support and loss brought them closer, and they decided to go away for a week together.

During this time, facing the loss of their spouses and the existential awareness of death that ensued, the two men finally acknowledged their lifelong sexual and emotional attraction to each other. They were able to consider a cultural identity other than male, black or white, and husband and father; they now were able to see themselves as part of a couple with a same-sex orientation. As they began exploring the possibility of actually moving in with

each other (Mr. M. was able to move because he worked freelance and was semiretired), they realized that they had many issues to address, including coming out to children and extended family, dealing with the interracial nature of their relationship, and facing the fears of disclosure that had kept both of them apprehensive and friendless except for each other.

In spite of the feelings they both had about not being able to live as gay men during the earlier parts of their lives, both felt that having their children had made the sacrifice more than worth it.

Cultural Features of the Relationship Between the Individual and the Clinician

This part of the OCF indicates that working with this couple would require an appreciation for the effect of having hidden their sexual orientation for so long and from people they love who presumed otherwise. The therapist would also have to consider their very different religious perspectives: Mr. M. was a nondenominational Christian, and Mr. H. was a more traditional Southern Baptist, with family who did not share the view that homosexuality was acceptable. Interestingly, the children (in their 30s) accepted the relationship and were happy that their fathers were not going to be alone. It took patience and a few years for the extended family to come around and accept the relationship.

Therapists working with such a couple would need to be careful about their own values and beliefs about sexual orientation and male-male sexuality. The gender and sexual orientation of the therapist might affect notions of betrayal of the legacy of the marriages, and countertransference feelings about interracial relationships might arise.

Dual Minority Identity

LGB individuals not only deal with prejudice and inequities by virtue of their sexual minority status but may also have to deal with existing bias and inequities of care as members of an ethnic/racial minority. In some ethnic/racial groups, same-sex orientation is associated with the dominant white culture. Negotiating this dual minority identity presents specific challenges for individuals who are developmentally most often aware first of the ethnic/racial identity as represented by the family in which they live and second of the sexual minority identity, with varying degrees of coalescing these dual identities into a coherent sense of self and in relationship to family and others (Bowleg et al. 2008; Glick and Golden 2010; Grov et al. 2006). Although many LGB in-

dividuals recall significant same-sex interest and curiosity in early childhood, the conscious awareness, meaning, and language to understand this aspect of identity are often later than one's identification with the family of origin and the sociocultural group to which one is attached. Ethnic minority groups vary in how open LGB people can be. Cultural groups, religious affiliations, geographic areas, and generations vary greatly in terms of how LGB members are treated (Glick and Golden 2010; Jamil et al. 2009). Within an ethnic or racial minority, individual families may vary in terms of knowledge, comfort, and acceptance of LGB family members. There is a great continuum from denial of same-sex sexual orientation to tolerance, acceptance, or embracing that often makes disclosure within one's ethnic group anxiety-provoking. As the younger generations experience LGB peers and access the Internet, the way that LGB people are perceived and treated may be changing for the better over time (Gomillion and Guiliano 2011).

Case 4

Cultural Identity of the Individual

J.R. is a 22-year-old self-identified gay male African American graduate student of African American heterosexual parents who presented for psychotherapy for anxiety about a 2-year relationship with a 49-year-old white man. When J.R. was 12 years old and just beginning to self-identify as gay, his father died of an acute heart attack. His mother, a practicing Southern Baptist, turned to the church for emotional and social support. J.R. would attend church with his mother but had an early awareness that his sexual orientation was considered sinful in the Baptist denomination.

Psychosocial Stressors and Cultural Features of Vulnerability and Resilience

As the older of two children, J.R. had to care for his mother, who was bereft and working two jobs to support the family after the loss. J.R. took care of his younger sister after school and buried himself in academics, excelling and getting a full scholarship that required him to leave home to be away at school. His father's death and his subsequent role as surrogate father hindered his acceptance of his gay identity until college. He entered the gay social setting by attending a group called Black and White Men Together and found himself in a relationship with the older white man that he found very safe, comforting, and supportive. However, because his partner was about to turn 50, he was being pressured to decide if they were going to move in together.

Cultural Features of the Relationship Between the Individual and the Clinician

J.R. was aware that he was becoming increasingly anxious and came for therapy, deliberately wanting a gay therapist. He was assigned to a white psychiatry resident, who was involved in a relationship with an African American male himself but unbeknownst to J.R. During the course of therapy, the patient became aware that he had chosen a white gay therapist and wondered what that meant about his own racial identity, evoking many countertransference issues in the parallel relationship of the therapist. Because the therapist was only a few years older than the patient, issues of the age difference between J.R. and his partner emerged as well. J.R. began to understand that some of the attraction to the older white man had to do with a complex set of feelings (anger, sadness, erotic interest, fear) toward his father. He understood that losing his father at the time when his same-sex orientation was emerging set in motion the search for a father substitute.

Over the course of the therapy, J.R. began to wonder what it might be like to date men of his own age and wondered if younger white men would find him attractive, eliciting some anxiety in the therapist, who brought these issues into supervision with an older white man. J.R. even asked if the therapist had ever dated a black man. The resident explored these issues, asking J.R. to talk about his own development as an African American male, including his religion, which he felt was not accepting of his homosexuality. What emerged were beliefs that his father, and the black community in general, would not accept him because of his sexual orientation and his own feelings of racial inferiority. Over time, J.R. was able to let his older white partner know that he needed to date more men before he would be ready to settle down. He began dating men more in his peer group and slowly began to make friends with other gay African American men as well. Having a white gay therapist allowed J.R. to avoid the disapproval from an African American while working out his issues with his sexual identity. Although J.R. had little difficulty accepting himself as gay, he was anxious about being gay in the African American community. Having grown up in a mixed ethnic/racial community, he felt more comfortable with his racial identity, which he understood had been affirmed by his father and mother well before his father's untimely death. The developmental task was to integrate both aspects of his identity to reduce his anxiety and to forge a complete sense of himself.

This vignette illustrates the complex interplay of individual identity formation, the psychological effect of an unexpected parental loss, and beliefs about race and sexual orientation.

Effect of Bullying on Sexual Minorities

The bullying of sexual minorities by their heterosexual peers has attracted national attention in recent years because of media coverage of such incidents. Many of these incidents resulted in the suicide of the bullied individual because of the resultant shame and humiliation. Sexual minorities have increased vulnerability to being bullied, and studies have documented increased rates of verbal, physical, and sexual assaults in the LGB adolescent population (Birkett et al. 2009; Friedman et al. 2011) and even among youths assumed to be LGB. Racial prejudice and antireligious attitudes may be addressed in schools, but homophobia is most often left unaddressed, contributing further to the internalization of self-loathing and shame about sexual orientation (Saewyc et al. 2006).

Lazare and Levy (2011) have recently written about the extraordinary effect of humiliation on the self, explicating that the very language that is used in the course of humiliation is tantamount to assault and murder. The taunts and physical abuse are experienced as an invalidation of the self and in extreme cases may in fact drive children and adolescents to suicidal thinking and behavior (Berlan et al. 2010; Friedman et al. 2011).

Recent publicity of suicides of bullied LGB children and adolescents prompted a multinational response on the Internet via the It Gets Better Project. The project features video testimonials by LGB people of all ages that life after coming out, although initially difficult, does get better with time and support (www.itgetsbetter.org).

The trauma of repeated denigration and humiliation of the self by others might last a lifetime. In many older LGB people, the fear of such humiliation may impair intimate or social relationships.

Case 5

Mr. X. is a 45-year-old white gay-identified man who came to therapy to work on issues of “self-esteem and depression.” He had been enormously successful in business and had amassed a small fortune that would enable him to live without working for the rest of his life should he choose to do so. At age 30, he had presented with an acute depression, for which he received a combination of an antidepressant and psychotherapy. He managed to return to work and was not seen again until age 45. Despite his financial success, Mr. X. had had significant doubts about his ability to establish a long-term relationship and

had intense ambivalent feelings about his parents, who he felt had not protected him during his childhood from significant bullying that occurred on the school bus and the playgrounds.

The oldest of four children from a working-class family, Mr. X. had been verbally and physically bullied from grade school through middle school because of assumptions about his sexual orientation. Names like “sissy” and “fag” were repeatedly used to belittle him, to the point that he didn’t want to go to school, but in spite of that, he did very well academically. His parents minimized his concerns, and he felt that they too were disappointed in him.

As a result of his feeling disconnected from his family, he dived into academics and graduate school with a vengeance and felt that despite his family’s lack of support, he had “made something of himself” that should make them proud. Even as an adult, the memories of the bullying left doubts about his self-worth and value as a person, especially to his parents. Even after Mr. X. confronted them about what had happened, they would not accept that they had done anything wrong. His parents wondered how he could be so upset with them given that he had “turned out so well.”

After 3 years of therapy, working through the cumulative trauma of the bullying he felt in school, he came out at work and found that he was received very well and admired for his professional work and character. He was able to let go of the fantasy that his parents would ever be able to give him the support he wanted and turned his attention to the future rather than the past.

Common Issues for Lesbian, Gay, or Bisexual People Presenting for Treatment Throughout the Life Cycle

Many of the issues that bring LGB people to seek treatment are similar to those of non-LGB people. Clinicians should have a conceptual framework in which to assess how these issues may present differently in sexual minorities. Using the DSM-5 OCF will help the clinician to facilitate a complex assessment, including discerning factors in the individual, family, and social context. The following list is based on common issues at different phases of the life cycle and is not meant to be all-inclusive. An overarching issue is where in the life developmental course the individual(s) first identified as a sexual minority and how that interacts with the current presentation. In an assessment, the clinician should focus on the “Cultural Identity of the Individual” and “Psychosocial Stressors and Cultural Features of Vulnerability and Resilience” categories of the OCF.

Childhood and Adolescence

- Early manifestations of atypical behavior may appear in the prepubertal phase and be more of a concern for parents and teachers than for the individual himself or herself.
- There is a great range of comfort with emerging sexual feelings in children, varying by temperament, family context, values, and religious prohibitions or permissions for displays of sexuality and affection.
- As puberty begins, gender, social, religious, and cultural expectations are clearly visible in the environment and may manifest in terms of low self-esteem, negative sense of self, fears of being rejected by parents and peers, or defenses that include both hiding or proclaiming being “different” from the peer group norm. Teenagers may engage in heterosexual behavior as an attempt to deny their more predominant sexual orientation, and teenage pregnancy may result from this attempt to reinforce “sexual normality.”
- During the period of emerging sexual interests, the clinician needs to assess the level of interaction on the Internet, including the use of chat sites and social media. For youths in isolated geographical areas, using social media to establish a virtual peer support group may be quite helpful in moving through the stages of self-acceptance.
- In adolescence, when peers are beginning to spend time with others who are objects of affection and sexual interest, LGB youths often feel isolated, depressed, and/or anxious. Alternatively, individuals who are unable or unwilling to hide their sexual orientation may brandish it like a badge of courage or honor, expecting the world to embrace them. Urban youths may find like-minded people to support them more easily than youths in less-populated areas geographically.
- Adolescence is also the time when dual minority identity youths struggle to understand the interplay of race/ethnicity and sexual orientation. The consolidation of an identity as a gay or lesbian or bisexual person may include the belief that becoming a parent must be forsaken. As more LGB people become parents, this preclusion may be less a part of the consolidation of a sexual minority identity.
- Clinicians also must remember that many of the major mental illnesses may emerge during this phase of development. Providers should exercise caution in underdiagnosing illness (attributing problems to the stigma or

trauma of coming out) or overdiagnosing illness (underestimating the effect of rejection by family and peers, bullying, and isolation).

Young Adulthood to Middle Age

- After adolescence, sexual minorities may lag somewhat behind their peers in developing interpersonal and social skills if they have been “closeted” and supported mostly by peers who are unaware of their sexual orientation.
- Many LGB young people devote themselves to education, finding careers, and putting off the more intimidating tasks of engaging in relationships, although sexual behavior may be occurring clandestinely or outside of the social peer group. This may put youths at risk for being used by others, and the risk for HIV and other sexually transmitted diseases is increased in those who separate their emotional life from their sexual behavior.
- Issues of how to manage sexual orientation disclosure in the workplace or educational experience may present as anxiety. Clinicians must be careful to not impose their own feelings about disclosure but to assess the level of safety in such disclosures.
- Social pressure to partner or have multiple sexual relationships will vary within the multiple LGB “cultures.”
- The acknowledgment by others of a breakup of a relationship may be less supportive, possibly because of the belief that same-sex relationships are less serious. Clinicians should be aware of how the development of marriage equality will affect concepts of coupling in the upcoming decades.
- Issues of monogamy versus fidelity or open relationships may emerge in couples.
- In the mid 20s and 30s, yearnings to parent or be generative may arise in individuals or couples. Clinicians must attend to assessing the readiness of each patient to be “out” as a gay or lesbian parent and the discrepancies between members of a couple in terms of how “outness” can precipitate difficulties.
- Developing a same-sex relationship may affect the individual’s relationship with the family of origin. Clinicians can help patients assess their assumptions about how their sexual orientation might be received and prepare coping strategies in the event of rejection. Clinicians should help patients to understand that parents may need time to metabolize the information,

just as the individual needed time to come to terms with his or her own sexual identity.

Middle Age

- Patients presenting in middle age may have been “out” for a considerable time or may be disclosing their sexual identity for the first time.
- Those who have been “out” for a long time may be trying to manage the particular way in which aging is seen in the various LGB communities.
- Overt images of sexuality and youth pervade all of society but appear to be particularly dominant in gay male populations, along with continued anxiety about sexual performance and risk for HIV.
- Men and women who are first coming out in their middle years may present with a disconnect between feeling mature in their work life and feeling adolescent in their longing for sexual intimacy and relationships. Clinicians can help patients develop a plan to integrate the adolescent feelings of sexual arousal and infatuation with the rest of their lives. This may also include issues of coming out to both children and elderly parents.

Older Age

- The issues that arise in the later years will depend a great deal on how “out” the person has been throughout his or her life and whether he or she is coupled, single, or widowed.
- All of the developmental tasks of the later years of life emerge: nearing the end of or completing a work life, beginning to reconcile physical and medical issues, and facing the loss of friends and/or significant others.
- The level of “outness” may affect how much social and psychological support is available to buffer the individual through the changes that aging brings. Those who are currently elderly may have had a very different, more inhibited experience as their true selves than those who are now young, who will face aging with years of social interaction and an LGB identity that is more authentic, if not necessarily easier.
- Elderly people with mental illness and/or in nursing homes or supervised institutions may feel particularly invisible and lonely.

- Finally, taking stock of one's life, preparing for death, and grieving the loss of a significant other may be less acknowledged by society in LGB individuals.

Assessment

Sexual/Cultural Identity of the Individual

Assessing the sexual minority patient who presents for treatment requires an organized approach because it is a complex formulation. It may be useful to conceptualize the various domains of development as cognitive, affective, and behavioral. In other words, what does the person know, think, and feel, and what does he or she *do* with that knowledge and those thoughts and feelings? Intellectual capacity, social skills, selfobject integration, and the degree of attachment, as well as cultural attitudes and sense of self-efficacy, all contribute to how and when a person begins both the internal and the external process of coming out. In the case of a dual minority patient, attention must be paid to the interplay of race/ethnicity/culture with sexual orientation development.

In the clinical setting, once the issue of same-sex orientation has been identified as a concern in the therapy, the therapist must create a safe place to explore to what degree negative messages and beliefs have been internalized in the individual. These social messages, family and cultural beliefs, religious doctrine, and the omission of positive affirming messages get inserted into the developing sense of self. Antihomosexual beliefs are internalized from early childhood, so starting with questions that are part of the history or assessment can set the stage for later exploration as to how deeply rooted these beliefs might be and their effect on the patient's current experience and functioning, which is relevant for the "Psychosocial Stressors and Cultural Features of Vulnerability and Resilience" part of the OCF.

The following queries may be useful for the clinician to compose questions for the patient to develop an understanding about how sexual identity develops for any individual patient:

- To what degree is the presenting concern specifically about sexual orientation?
- How does sexual orientation affect other concerns that bring the patient to treatment?
- At what age does the person present for help?

- At what age did the person first become aware consciously of same-sex or bisexual feelings?
- At what age is the person trying to integrate sexual feelings and affectional preference into other components of life stage development?
- What are the cognitive, affective, and behavioral developmental stages of the individual?
- What is the nature of his or her support system?
- What is the relationship between the individual's understanding of self and the cultural context in which he or she grew up and is living? How diverse were the people with whom his or her parents interacted? What are the individual's beliefs about people from different cultural or religious backgrounds? Which ones does the individual share?
- Does the person have a belief about the origins of his or her sexual orientation?
- How syntonetic or dystonic are those beliefs with family, religious, and cultural beliefs?
- In what ways has the individual considered his or her sexual orientation to be a limiting or enhancing aspect of his or her personality and experience throughout life?

To ascertain the answers to the queries above, the clinician must place the questions in the context of a general psychiatric assessment. The following is an example of how that initial assessment might occur.

“We have been talking about your childhood and adolescence, and sexuality is an important part of how we grow and develop into adults. I'd like to ask you about when you first became aware of your sexual feelings. About how old were you? Which gender did you find yourself thinking about mostly? How did you feel about having sexual feelings? Did your family discuss sexual issues?”

Making normalizing statements can facilitate the patient's feeling safer while disclosing feelings that are anxiety provoking.

“Many people in childhood or adolescence have sexual feelings that they think are wrong or make them feel different from others. For example,

sexual interest, or love, toward someone of the same gender can be confusing, frightening, exciting, or all of those.”

After establishing a context, moving from general to more specific questions will allow the patient to express useful information that may provide insights into the developmental phase of coming out and barriers to consolidating a positive self-identity.

“Can you tell me about the most important people in your life now or from the past (such as family, friends, others)?”

“Can you tell me about the nature of those relationships? Are any of them emotionally intimate? Sexually intimate? If not, would you like them to be? Are you currently sexual with yourself or others? Would you consider yourself sexually attracted to males or females or both? How do you feel about your sexual feelings?”

The clinician also needs to validate the patient’s developing identity when he or she has shared this information. However, many patients will not provide this information and instead will depend on the clinician to initiate the dialogue surrounding sexual orientation. In fact, studies indicate that only one-third of clinicians ask their adolescent patients about their sexual orientation, with practitioners citing a lack of knowledge, a fear of offending patients, an inability to identify ways to ask about sexual orientation, and unfamiliarity with resources as reasons for not initiating this dialogue (Lena et al. 2002).

Clinicians can initiate a dialogue on sexual orientation in various ways. An overarching theme revolves around the need to ask for feelings and desires rather than an identity label. Some examples that can be used with adolescents and young adults are

“Are you sexually active/hooking up? With guys, girls, or both?”

“Some people your age are beginning to date/hook up with other teens. Are any of your friends? Are you?”

“When you think about dating, would you want to date guys, girls, or both?”

“Do you have a crush on anybody?”

The clinician needs to discuss sexual orientation and sexual behavior across the life cycle because social functioning, isolation, and anxieties about being a sexual minority may be a component of the problem(s) for which the patient has sought treatment.

DSM-5 and the Cultural Formulation Interview

The Cultural Formulation Interview (CFI) in DSM-5 (American Psychiatric Association 2013) offers some assistance in formulating questions for a culturally appropriate assessment for all patients. The CFI consists of a 16-question core module with 12 supplementary modules and an informant module, each with their own questions. There are as many as 34 questions for “Cultural Identity,” although some questions are repeated from the core CFI. The four domains of assessment in the CFI are 1) Cultural Definition of the Problem (questions 1–3); 2) Cultural Perceptions of Cause, Context, and Support (questions 4–10); 3) Cultural Factors Affecting Self-Coping and Past Help Seeking (questions 11–13); and 4) Cultural Factors Affecting Current Help Seeking (questions 14–16) (see Appendix 1, “DSM-5 Outline for Cultural Formulation, Cultural Formulation Interview, and Supplementary Modules”).

The core CFI questions 6 and 7 are the most relevant for clinicians assessing LGB individuals to see how their identity as an LGB person affects their supports and either helps or hinders their improvement and how it will affect their treatment, and questions 8, 9, and 10 help the clinician to open the discussion of cultural identity and its role in the problem by asking the patient to identify the key parts of his or her background and identity. Question 16 addresses concerns that the patient may have about the clinician and how the clinician’s gender, ethnicity, and sexual orientation will affect the doctor-patient relationship. Although these questions emphasize the cultural aspects of the doctor-patient relationship, the clinician should consider the meaning of the questions and the responses with a dynamic understanding of other aspects of the transference relationship.

For a more in-depth interview, we suggest that the clinician consider using questions 29–32 of CFI supplementary module 6, “Cultural Identity,” which ask patients to describe their sexual orientation, the problems that it has caused them, whether it is a barrier to their getting care, and if they feel that health care workers have preconceived notions about them that are not helpful. Other modules that may be useful are CFI supplementary module 3, “Social Network,” to understand how a patient’s network can support or hinder him or her through treatment; the appropriate age-related module, such as supplementary module 9, “School-Age Children and Adolescents,” or supple-

mentary module 10, "Older Adults"; and supplementary module 8, "Patient-Clinician Relationship," if patients have issues brought out by question 16 of the core CFI (see Table 8-4; Appendix 1).

Implications for Clinical Practice

Understanding the normal developmental processes for forming a sexual minority identity has substantial implications for clinical practice (Hart and Heimberg 2001). Mental health providers should also be knowledgeable about the various unique medical issues of sexual minorities, for example, those issues affected by increased and internalized stress, sexual behaviors and sexually transmitted diseases, eating disorders, and substance use.

Of critical importance is distinguishing medical and mental health issues that are related to sexual orientation from those that are independent but affected by sexual minority status. Providers are at risk for underpathologizing or overpathologizing the presenting problems of sexual minorities. Viewing the development of a sexual minority identity as a culturally informed process provides a more complex view of the multiple intrapsychic, familial, cultural, and social forces that affect an individual.

Atypical gender behavior may precipitate parents' bringing their young children in for evaluation because of concern that their child is gay or gender dysphoric. Negotiating with parents who are uncomfortable with their child's cross-gender behavior requires knowledge, skill, and patience. Providers must guard against their own countertransference and alliance with the parents' concerns about the well-being of the child.

LGB individuals may also present to the health care system during the time of coming out because they have a greater risk for mental health struggles during this time. These individuals are faced with the significant psychosocial burden of disclosure in the context of few supportive influences. As with their heterosexual peers, LGB children and adolescents present to the mental health system when in the throes of an incipient mental disorder. Uninformed or covertly hostile providers may impede adequate care or, worse, may exacerbate the psychological stress and disorder.

In addition, there is a "greater risk of psychosocial problems associated with earlier age of self-identification" (Kreiss and Patterson 1997, p. 268).

Table 8–4. Questions from the Cultural Formulation Interview (CFI) and supplementary modules for lesbian, gay, and bisexual patients

Core Questions From the CFI

Stressors and Supports

Elicit information on the person's life context, focusing on resources, social supports, and resilience. May also probe other supports (e.g., from coworkers, from participation in religion or spirituality).

6. Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others?

Focus on stressful aspects of the individual's environment. Can also probe, e.g., relationship problems, difficulties at work or school, or discrimination.

7. Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with money, or family problems?

Role of Cultural Identity

Sometimes, aspects of people's background or identity can make their [PROBLEM] better or worse. By *background* or *identity*, I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, or your faith or religion.

8. For you, what are the most important aspects of your background or identity?
9. Are there any aspects of your background or identity that make a difference to your [PROBLEM]?
10. Are there any aspects of your background or identity that are causing other concerns or difficulties for you?

Clinician-Patient Relationship

Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations.

16. Have you been concerned about this and is there anything that we can do to provide you with the care you need?

Table 8–4. Questions from the Cultural Formulation Interview (CFI) and supplementary modules for lesbian, gay, and bisexual patients (*continued*)

CFI Supplementary Module 6, “Cultural Identity”

Sexual Orientation Identity

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: Sexual orientation may also be important to individuals and their comfort in seeking health care. I would like to ask you some questions about your sexual orientation. Are you comfortable answering questions about your sexual orientation?

29. How would you describe your sexual orientation (e.g., heterosexual, gay, lesbian, bisexual, queer, pansexual, asexual)?
30. Do you feel that your sexual orientation has influenced your [PROBLEM] or your health more generally?
31. Do you feel that your sexual orientation influences your ability to get the kind of health care you need for your problem?
32. Do you feel that health care providers have assumptions or attitudes about you or your [PROBLEM] that are related to your sexual orientation?

Source. Reprinted from American Psychiatric Association 2013.

This is therefore a time when clinicians can play an essential role in helping patients work through these problems.

The fear of rejection can create an incongruity between the patient's feelings and behaviors and his or her parents' values, thus leading to a fragmented identity. The same fear hinders the disclosure to parents and peers, isolating the child, who may then develop maladaptive coping strategies, such as use of sex and/or substances to allay anxiety and fear. During this time, clinicians can play an important role in aiding adolescents in differentiating from their parents, thus increasing the congruence between the patient's feelings and behaviors and values, thereby fostering the creation of a fuller identity (Browning 1987).

Moreover, the coming out period is a time when LGB youths risk rejection from their parents, friends, and classmates. One study reported that up to 40% of LGB adolescents lose at least one friend when they come out. Clini-

cians can play a valuable supportive role during this time (Hart and Heimberg 2001). Rejection by families has been reported to be a predictor of negative health outcomes in sexual minorities. Studies have reported associations between health risk behaviors and sexual orientation (Garofalo et al. 1998; Ryan et al. 2009). Finally, an increased risk of suicidal ideation has been reported in the time immediately after coming out, indicating a crucial period for involvement with mental health professionals (Bagley and Tremblay 2000).

Despite the significant psychosocial stressors faced by sexual minority individuals, clinicians can undertake substantial interventions to improve the therapeutic alliance with LGB patients. It is incumbent on the trainee or therapist to assess his or her biases toward LGB individuals and to use supervision in a thoughtful manner to help achieve this goal. Homophobia or heterosexism on the part of the therapist represents a significant therapy-interfering behavior that must be rectified before the therapy can progress. Moreover, we must assess our patients' biases because many bring notions of internalized homophobia into the therapeutic relationship (Lock and Kleis 1998). The therapist should wonder if the patient has asked any questions or made any assumptions about the therapist's sexual orientation and what that might mean.

The clinician needs to remember that coming out is an individual and iterative process. It is best to assess a patient's support system before supporting the decision to come out. Adolescents may impulsively declare their sexual orientation as a means of defending against fears of being exposed by peers or even as an attempt to rebel and act out against their parents or adult authority figures. It may be better for someone to stay "in the closet" if one can predict possibly negative ramifications. In addition, the process is fluid, and identity labels can change over time, which is perfectly acceptable. The clinician must regularly assess the patient's place in the developmental schema, keeping in mind that just because one fails to self-identify as a sexual minority does not mean that one is not thinking about it; it might mean that the patient is not yet ready to assume a label. Moreover, coming out is a lifelong process (Rosario et al. 2006). The use of Klein's grid (Table 8–2) can be quite helpful at any age in developing a dialogue between patient and therapist about the effect of sexual orientation at different stages of the life cycle. Older patients may present with having been "out" for a long time or may have never told anyone. In the later stages of life, taking a sexual or relationship history is critical to understanding the effect of being a

sexual minority in a culture in which LGB people are assumed to be young. The following vignette illustrates some of the concerns in older patients.

Case 6

Ms. G. is a 78-year-old who presented with late-onset depression. Having not had any children, she had lived with a “cousin” for 45 years. Her housemate had died about a year ago, leaving Ms. G. alone and depressed. Hospitalized on a geriatric psychiatry unit, she was slowly able to tell the story of how she and her housemate had met while working in an academic institution and had been lovers since then. Afraid that they would lose their careers, they kept to themselves and did not participate in any social interaction with other LGB social groups, even when they were young. The significance of the loss of her “spouse” went unnoticed by others who were not aware of the nature of the relationship, and thus her grieving process, isolation, and lack of support sent her spiraling downward. With careful inquiry and an empathic response to her loss, her grief emerged and was honored by the treatment team. Connecting her to resources for elderly LGB people provided much-needed support.

LGB individuals continually must decide whether to come out to every person that they encounter, including family, friends, colleagues, bosses, and classmates. These struggles related to whether to come out do not simply disappear with identity acceptance; rather, they continue throughout a person’s life, so it is important for clinicians to continue to assess a patient’s readiness to come out throughout the life span.

Conclusion

LGB individuals have been a part of society since the time of ancient civilizations. They have a higher prevalence of mental illnesses, substance abuse, and suicide attempts than does the majority population. They may present for a psychiatric crisis or for an outpatient intake. Because they can choose whether to disclose their sexual orientation, it is incumbent on the clinician to inquire if the patient has had same-sex partners and assess his or her desires, feelings, and behaviors, as well as his or her role in the family and community system. The clinician should not presume to know the sexual orientation of the patient on the basis of physical presentation, gender, gender role, race, or ethnicity.

The clinician should pay particular attention to sexual identity development in adolescents because many want to disclose but are inhibited from doing so. The assessment of any LGB person, particularly an adolescent, includes inquiring if he or she has been a target of bullying, which can increase stress and affect the patient's level of functioning, social interactions, and self-esteem. Because sexual minorities remain stigmatized throughout much of the world, an increased emotional and social vulnerability may result in suicidal ideation or a suicide attempt. Clinicians also need to be aware of their own biases that may interfere with engagement or adherence. An important aspect of the assessment is to determine the individual's developmental stage of identity development and if he or she has come out and to whom.

By being mindful of the stages involved in development of a sexual orientation identity, clinicians are better able to perform a culturally appropriate assessment and provide developmentally appropriate and therapeutically oriented care. The use of the DSM-5 OCF and the CFI is also helpful in assessing the LGB individual in the context of multiple communities.

References

- Adams HL, Phillips L: Ethnic related variations from the Cass model of homosexual identity formation: the experiences of two-spirit, lesbian and gay Native Americans. *J Homosex* 56(7):959–976, 2009
- Allen DJ, Oleson T: Shame and internalized homophobia in gay men. *J Homosex* 37(3):33–43, 1999
- Almeida J, Johnson RM, Corliss HL, et al: Emotional distress among LGBT youth: the influence of perceived discrimination based on sexual orientation. *J Youth Adolesc* 38(7):1001–1014, 2009
- American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*. Washington, DC, American Psychiatric Association, 1952
- American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, 2nd Edition. Washington, DC, American Psychiatric Association, 1968
- American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, 3rd Edition. Washington, DC, American Psychiatric Association, 1980
- American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, 3rd Edition, Revised. Washington, DC, American Psychiatric Association, 1987

- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000
- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Washington, DC, American Psychiatric Association, 2013
- Bagley C, Tremblay P: Elevated rates of suicidal behavior in gay, lesbian, and bisexual youth. *Crisis* 21(3):111–117, 2000
- Bayer R: Homosexuality and American Psychiatry. Princeton, NJ, Princeton University Press, 1987
- Berlan ED, Corliss HL, Field AE, et al: Sexual orientation and bullying among adolescents in the Growing Up Today Study. *J Adolesc Health* 46(4):366–371, 2010
- Bhugra D: Controlled comparison of attitudes of psychiatrists, general practitioners, homosexual doctors and homosexual men to male homosexuality. *J R Soc Med* 82(10):603–605, 1989
- Bieber I, Dain HJ, Dince PR, et al: Homosexuality: A Psychoanalytic Study. New York, Basic Books, 1962
- Birkett M, Espelage DL, Koenig B: LGB and questioning students in schools: the moderating effects of homophobic bullying and school climate on negative outcomes. *J Youth Adolesc* 38(7):989–1000, 2009
- Blanchard R: Fraternal birth order and the maternal immune hypothesis of male homosexuality. *Horm Behav* 40(2):105–114, 2001
- Bolton SL, Sareen J: Sexual orientation and its relation to mental disorders and suicide attempts: findings from a nationally representative sample. *Can J Psychiatry* 56(1):35–43, 2011
- Boswell J: Christianity, Social Tolerance, and Homosexuality. Chicago, IL, University of Chicago Press, 1980
- Bowleg L, Burkholder G, Teti M, et al: The complexities of outness: psychosocial predictors of coming out to others among black lesbian and bisexual women. *J LGBT Health Res* 4(4):153–166, 2008
- Browning C: Therapeutic issues and intervention strategies with young adult lesbian clients: a developmental approach. *J Homosex* 14(1–2):45–52, 1987
- Burgard SA, Cochran SD, Mays VM: Alcohol and tobacco use patterns among heterosexually and homosexually experienced California women. *Drug Alcohol Depend* 77(1):61–70, 2005
- Byne W: Biology of sexual minority status, in *The Health of Sexual Minorities*. Edited by Meyer IH, Northridge ME. Berlin, Springer-Verlag, 2007, pp 65–90
- Cass V: Homosexual identity formation: a theoretical model. *J Homosex* 4(3):219–235, 1979

- Cass V: Sexual orientation identity formation, in *Textbook of Homosexuality and Mental Health*. Edited by Cabaj RP, Stein TS. Washington, DC, American Psychiatric Press, 1996, pp 227–252
- Charcot JM, Mannon V: Inversion du sens genitale. *Archives de neurologie* 3:53–54, 1882
- Cochran SD, Mays VM: Disclosure of sexual preference to physicians by black lesbian and bisexual women. *West J Med* 149(5):616–619, 1988
- Cochran SD, Mays VM, Alegria M, et al: Mental health and substance use disorders among Latino and Asian American lesbian, gay, and bisexual adults. *J Consult Clin Psychol* 75(5):785–794, 2007
- Coleman E, Rosser BR: Gay and bisexual male sexuality, in *Textbook of Homosexuality and Mental Health*. Edited by Cabaj RP, Stein TS. Washington, DC, American Psychiatric Press, 1996, pp 707–721
- Cox N, Dewaele A, van Houtte M, et al: Stress-related growth, coming out, and internalized homonegativity in lesbian, gay, and bisexual youth: an examination of stress-related growth within the minority stress model. *J Homosex* 58(1):117–137, 2011
- Dykes B: Problems in defining cross-cultural “kinds of homosexuality”—and a solution. *J Homosex* 38(3):1–18, 2000
- Ellis H, Symonds JA: *Sexual Inversion* (1897). London, Wilson and Macmillan, 1975
- Faderman L: *Surpassing the Love of Men: Romantic Friendship and Love Between Women From the Renaissance to the Present*. New York, Quill/William Morrow, 1981
- Fergusson DM, Horwood LJ, Beautrais AL: Is sexual orientation related to mental health problems and suicidality in young people? *Arch Gen Psychiatry* 56(10):876–880, 1999
- Fitzpatrick R, Dawson J, Boulton M, et al: Perceptions of general practice among homosexual men. *Br J Gen Pract* 44(379):80–82, 1994
- Flores G, Gee D, Kastner B: The teaching of cultural issues in U.S. and Canadian medical schools. *Acad Med* 75(5):451–455, 2000
- Floyd FJ, Bakeman R: Coming-out across the life course: implications of age and historical context. *Arch Sex Behav* 35(3):287–296, 2006
- Freud S: Letter to an American mother. *Am J Psychiatry* 107:787, 1951
- Friedman MS, Marshal MP, Guadamuz TE, et al: A meta-analysis of disparities in childhood sexual abuse, parental physical abuse, and peer victimization among sexual minority and sexual nonminority individuals. *Am J Public Health* 101(8):1481–1494, 2011

- Garofalo R, Wolf RC, Kessel S, et al: The association between health risk behaviors and sexual orientation among a school-based sample of adolescents. *Pediatrics* 101(5):895–902, 1998
- Glick SN, Golden MR: Persistence of racial differences in attitudes toward homosexuality in the United States. *J Acquir Immune Defic Syndr* 55(4):516–523, 2010
- Goffman E: *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs, NJ, Prentice Hall, 1963
- Gomillion SC, Giuliano TA: The influence of media role models on gay, lesbian, and bisexual identity. *J Homosex* 58(3):330–354, 2011
- Grov C, Bimbi DS, Nanin JE, et al: Race, ethnicity, gender, and generational factors associated with the coming-out process among gay, lesbian, and bisexual individuals. *J Sex Res* 43(2):115–121, 2006
- Haas AP, Eliason M, Mays VM, et al: Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: review and recommendations. *J Homosex* 58(1):10–51, 2011
- Haber D: Gay aging. *Gerontol Geriatr Educ* 30(3):267–280, 2009
- Hart TA, Heimberg RG: Presenting problems among treatment-seeking gay, lesbian, and bisexual youth. *J Clin Psychol* 57(5):615–627, 2001
- Herdt G: Issues in the cross-cultural study of homosexuality, in *Textbook of Homosexuality and Mental Health*. Edited by Cabaj RP, Stein TS. Washington, DC, American Psychiatric Press, 1996, pp 65–82
- Herrell R, Goldberg J, True WR, et al: Sexual orientation and suicidality: a co-twin control study in adult men. *Arch Gen Psychiatry* 56(10):867–874, 1999
- Higgins JPT, Green S (eds): *Cochrane Handbook for Systematic Reviews of Interventions*, Version 5.1.0 [updated March 2011]. The Cochrane Collaboration, 2011. Available at: <http://www.cochrane-handbook.org>. Accessed May 15, 2014.
- Institute of Medicine: *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Washington, DC, National Academies Press, 2011. Available at: <http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx>. Accessed April 15, 2012.
- Jackson NC, Johnson MJ, Roberts R: The potential impact of discrimination fears of older gays, lesbians, bisexuals and transgender individuals living in small- to moderate-sized cities on long-term health care. *J Homosex* 54(3):325–339, 2008
- Jamil OB, Harper GW, Fernandez MI: Sexual and ethnic identity development among gay/bisexual/questioning (GBQ) male ethnic minority adolescents. *Cultur Divers Ethnic Minor Psychol* 15(3):203–214, 2009

- Joint Commission: Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual and Transgender (LGBT) Community: A Field Guide. Oakbrook Terrace, IL, Joint Commission, 2011
- Kertzner RM: The adult life course and homosexual identity in midlife gay men. *Annu Rev Sex Res* 12:75–92, 2001
- King M, Semlyen J, Tai SS, et al: A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry* 8:70, 2008
- Kinsey AC, Pomeroy WB: *Sexual Behavior in the Human Male*. Philadelphia, PA, WB Saunders, 1948, pp 639–656
- Kinsey AC, Pomeroy WB: *Sexual Behavior in the Human Female*. Philadelphia, PA, WB Saunders, 1954
- Kirkpatrick RC, Plato, Lévi-Strauss C: The evolution of human homosexual behavior. *Curr Anthropol* 41(3):385–413, 2000
- Klein F: *The Bisexual Option*. Binghamton, NY, Haworth Press, 1993
- Klitzman RL, Greenberg JD: Patterns of communication between gay and lesbian patients and their health care providers. *J Homosex* 42(4):65–75, 2002
- Kraft-Ebbing R: *Psychopathia Sexualis*. London, FA Davis, 1894
- Krajeski J: Homosexuality and the mental health professions: a contemporary history, in *Textbook of Homosexuality and Mental Health*. Edited by Cabaj RP, Stein TS. Washington, DC, American Psychiatric Press, 1996, pp 17–32
- Kreiss JL, Patterson DL: Psychosocial issues in primary care of lesbian, gay, bisexual, and transgender youth. *J Pediatr Health Care* 11(6):266–274, 1997
- Laumann EO, Gagnon JH: *The Social Organization of Sexuality: Sexual Practices in the United States*. Chicago, IL, University of Chicago Press, 1994
- Lazare A, Levy RS: Apologizing for humiliations in medical practice. *Chest* 139(4):746–751, 2011
- Lena SM, Wiebe T, Ingram S, et al: Pediatricians' knowledge, perceptions, and attitudes towards providing health care for lesbian, gay, and bisexual adolescents. *Ann R Coll Physicians Surg Can* 35(7):406–410, 2002
- Lewes K: *The Psychoanalytic Theory of Male Homosexuality*. New York, New American Publishers, 1989
- Liddle BJ: Recent improvement in mental health services to lesbian and gay clients. *J Homosex* 37(4):127–137, 1999
- Lock J, Kleis B: Origins of homophobia in males: psychosexual vulnerabilities and defense development. *Am J Psychother* 52(4):425–436, 1998

- Lock J, Steiner H: Gay, lesbian, and bisexual youth risks for emotional, physical, and social problems: results from a community-based survey. *J Am Acad Child Adolesc Psychiatry* 38(3):297–304, 1999
- Magee M, Miller DC: Psychoanalytic views of female homosexuality, in *Textbook of Homosexuality and Mental Health*. Edited by Cabaj RP, Stein TS. Washington, DC, American Psychiatric Press, 1996, pp 191–206
- Maguen S, Floyd FJ, Bakerman R, et al: Developmental milestones and disclosure of sexual orientation among gay, lesbian, and bisexual youths. *Appl Dev Psychol* 23:219–233, 2002
- Malyon AK: Psychotherapeutic implications of internalized homophobia in gay men. *J Homosex* 7(2–3):59–69, 1981–1982
- Marshall MP, Dietz LJ, Friedman MS, et al: Suicidality and depression disparities between sexual minority and heterosexual youth: a meta-analytic review. *J Adolesc Health* 49(2):115–123, 2011
- Mays VM, Cochran SD: Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the United States. *Am J Public Health* 91(11):1869–1876, 2001
- Meckler GD, Elliott MN, Kanouse DE, et al: Nondisclosure of sexual orientation to a physician among a sample of gay, lesbian, and bisexual youth. *Arch Pediatr Adolesc Med* 160(12):1248–1254, 2006
- Mercer CH, Bailey JV, Johnson AM, et al: Women who report having sex with women: British national probability data on prevalence, sexual behaviors, and health outcomes. *Am J Public Health* 97(6):1126–1133, 2007
- Merchant RC, Jongco AM, Woodward L: Disclosure of sexual orientation by medical students and residency applicants. *Acad Med* 80(8):786, 2005
- Meyer IH: Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychol Bull* 129(5):674–697, 2005
- Michaels S: The prevalence of homosexuality in the United States, in *Textbook of Homosexuality and Mental Health*. Edited by Cabaj RP, Stein TS. Washington, DC, American Psychiatric Press, 1996, pp 43–64
- Minton HL, McDonald GJ: Homosexual identity formation as a developmental process. *J Homosex* 9(2–3):91–104, 1983–1984
- Mustanski BS, Garofalo R, Emerson EM: Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youths. *Am J Public Health* 100(12):2426–2432, 2010
- O'Donnell S, Meyer IH, Schwartz S: Increased risk of suicide attempts among Black and Latino lesbians, gay men, and bisexuals. *Am J Public Health* 101(6):1055–1059, 2011

- Oriel KA, Madlon-Kay DJ, Govaker D, et al: Gay and lesbian physicians in training: family practice program directors' attitudes and students' perceptions of bias. *Fam Med* 28(10):720–725, 1996
- Perrin EC, Cohen KM, Gold M, et al: Gay and lesbian issues in pediatric health care. *Curr Probl Pediatr Adolesc Health Care* 34(10):355–398, 2004
- Pew Forum on Religion and Public Life: Gay marriage around the world. Washington, DC, Pew Forum on Religion and Public Life, July 9, 2009. Available at: <http://www.pewforum.org/2009/07/09/gay-marriage-around-the-world/>. Accessed April 29, 2014.
- Potter JE: Do ask, do tell. *Ann Intern Med* 137(5 Pt 1):341–343, 2002
- Rado S: A critical examination of the concept of bisexuality (1940). *Psychosom Med* 2:459–467. Reprinted in Marmor J (ed): *Sexual Inversion: The Multiple Roots of Homosexuality*. New York, Basic Books, 1965, pp 175–189
- Remafedi G: Suicide and sexual orientation: nearing the end of controversy? *Arch Gen Psychiatry* 56(10):885–886, 1999
- Rosario M, Schrimshaw EW, Hunter J, et al: Sexual identity development among gay, lesbian, and bisexual youths: consistency and change over time. *J Sex Res* 43(1):46–58, 2006
- Roselli CE, Stormshak F: The neurobiology of sexual partner preferences in rams. *Horm Behav* 55(5):611–620, 2009
- Russell ST, Joyner K: Adolescent sexual orientation and suicide risk: evidence from a national study. *Am J Public Health* 91(8):1276–1281, 2001
- Ryan C, Huebner D, Diaz RM, et al: Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. *Pediatrics* 123(1):346–352, 2009
- Saewyc EM, Skay CL, Pettingell SL, et al: Hazards of stigma: the sexual and physical abuse of gay, lesbian, and bisexual adolescents in the United States and Canada. *Child Welfare* 85(2):195–213, 2006
- Sanchez NF, Rabatin J, Sanchez JP, et al: Medical students' ability to care for lesbian, gay, bisexual, and transgendered patients. *Fam Med* 38(1):21–27, 2006
- Sandfort TGM, Dodge B: "And then there was the Down Low": introduction to Black and Latino male bisexualities. *Arch Sex Behav* 37(5):675–682, 2008
- Seal DW, Kelly JA, Bloom FR, et al: HIV prevention with young men who have sex with men: what young men themselves say is needed. Medical College of Wisconsin CITY Project Research Team. *AIDS Care* 12(1):5–26, 2000
- Shildlo A, Schroeder M, Drescher J (eds): *Sexual Conversion Therapy*. London, Haworth Press, 2001
- Siker J: *Homosexuality and Religion: An Encyclopedia*. Westport, CT, Greenwood Press, 2007

- Silverstein C: History of treatment, in Textbook of Homosexuality and Mental Health. Edited by Cabaj RP, Stein TS. Washington, DC, American Psychiatric Press, 1996, pp 3–16
- Skidmore WC, Linsenmeier JA, Bailey JM: Gender nonconformity and psychological distress in lesbians and gay men. *Arch Sex Behav* 35(6):685–697, 2006
- Smith DM, Mathews WC: Physicians' attitudes toward homosexuality and HIV: survey of a California Medical Society- revisited (PATHH-II). *J Homosex* 52(3–4):1–9, 2007
- Socarides C: Homosexuality. New York, Jason Aronson, 1978
- Stein TS: A critique of approaches to changing sexual orientation, in Textbook of Homosexuality and Mental Health. Edited by Cabaj RP, Stein TS. Washington, DC, American Psychiatric Press, 1996, pp 525–538
- Troiden RR: The formation of homosexual identities. *J Homosex* 17(1–2):43–73, 1989
- Ulrichs KH: The Riddle of “Man-Manly” Love: The Pioneering Work on Male Homosexuality (1862). Translated by Lombardi-Nash MA. Amherst, NY, Prometheus Books, 1994
- Vasey PL, Jiskoot H: The biogeography and evolution of female homosexual behavior in Japanese macaques. *Arch Sex Behav* 39(6):1439–1441, 2010
- Vasey PL, Pfaus JG: A sexually dimorphic hypothalamic nucleus in a macaque species with frequent female-female mounting and same-sex sexual partner preference. *Behav Brain Res* 157(2):265–272, 2005
- Waldner LK, Magruder B: Coming out to parents: perceptions of family relations, perceived resources, and identity expression as predictors of identity disclosure for gay and lesbian adolescents. *J Homosex* 37(2):83–100, 1999
- Westphal KFO: Die konträre Sexualempfindung. Symptom eines neuropathischen (psychopathischen) Zustandes. *Arch Psychiatr Nervenkr* 2(1):73–108, 1869

This page intentionally left blank

Transgender and Gender Nonconforming Patients

Dan H. Karasic, M.D.

Transgender and gender nonconforming people have existed through time and across cultures. In the early seventeenth century, a Basque conquistador named Alonso Díaz Ramírez de Guzmán was discovered to be the female-bodied Catalina de Erauso by birth. Polynesian (e.g., the Samoan *fa'afafine*) and Native American (two-spirited people) cultures are notable for the presence of persons with a third gender role, with both female and male features. Some of these transgender and gender nonconforming people, such as the *hijras* of India and the sworn virgins of Albania, remain visible in their cultures to this day.

In Western Europe and North America in the twentieth century, transgender identity was medicalized. The availability of hormone therapy and surgery permitted an effort to allow transgender people to alter their bodies to align with their gender identity. As patients with a psychiatric diagnosis, transsexu-

als' acceptance into some gender clinics was dependent on the ability to "pass" in the new gender role. In addition to hormonal therapies, various surgeries were developed to facilitate this binary change in gender. Genital surgery (vaginoplasty, metoidioplasty, phalloplasty), facial feminization surgery, tracheal shaving, and breast augmentation or male chest reconstruction, along with electrolysis, laser hair ablation, voice coaching, and image consulting, were all employed not only to improve the patient's sense of congruence with gender identity but also to improve the chances that patients could start anew in their new gender roles posttreatment, fading into society as male or female. Some patients were advised to cut off ties with their old lives and move to new cities where their old identities were not known. In societies hostile to gender non-conformity, this binary (male to female or female to male) transition was believed to have the best chance for success. Binary gender transition (social role transition, hormonal therapy, and surgery, often facilitated by psychotherapy) was effective in relieving gender dysphoria, although long-term outcomes of patients postsurgically showed increased medical and psychiatric morbidity and mortality compared with the general population (Dhejne et al. 2011).

However, transition-related medical care in the United States and many other countries has been unavailable to many people. Transgender care has been specifically excluded from insurance policies, and care providers have been unavailable in some areas. Hormones often are self-administered, without medical supervision. Transgender people in the United States, whether by choice or by financial circumstance, have not transitioned in the fully binary manner envisioned by early gender clinics, with low rates of receiving genital and other surgeries (Clements-Nolle et al. 2001).

Gender spectrum or nonbinary gender identities, such as *genderqueer*, have become more common. Some people identify as neither male nor female or somewhere in between. Some prefer limited or no body modifications. *Transgender*, *trans*, and *trans** are terms inclusive of a spectrum of gender identities; *transsexual* usually refers to those who seek or have undergone binary transition. Increasing numbers of people identify as transgender. Estimates of prevalence of transsexualism have been quite low when derived from those receiving hormones and surgery from centralized gender clinics (the ratios often quoted are 1:12,000 for male to female and 1:30,000 for female to male in the Netherlands) (Bakker et al. 1993), but the numbers at these gender centers have been increasing rapidly in recent years (Dhejne et al. 2014). However,

when identity, rather than surgical status, is asked, numbers are much higher. In a Massachusetts phone survey, 0.5% identified as “transgender” (Conron et al. 2012). In the Netherlands, 0.8%–1.1% identified as gender incongruent (Kuyper and Wijzen 2014). Assessing the number of transgender people in a population is best done with a two-part question. The first question asks the person’s current gender identity. The second question asks the sex assigned at birth. This captures people who currently have a trans identity as well as those who currently identify as male or female, not trans, although they have transitioned from the sex assigned at birth (Sausa et al. 2009).

The growing number of people with a transgender identity helped fuel the change in diagnosis from *gender identity disorder* (GID) to *gender dysphoria* in DSM-5 (American Psychiatric Association 2013). The diagnosis of gender identity disorder in DSM IV-TR (American Psychiatric Association 2000) was disliked by many transgender people and by health professionals because it labeled transgender identity as an illness. GID’s reference to the “other” sex reflected a binary view of gender identity not shared by all trans people. A survey of organizations involved in transgender health and/or advocacy showed strong opposition to the diagnosis (Vance et al. 2010). A consensus of members of the World Professional Association for Transgender Health (WPATH) recommended a diagnosis based on the distress of gender dysphoria rather than one based on transgender identity (Fraser et al. 2010). In DSM-5, the focus of the diagnosis of gender dysphoria is on the distress felt by the incongruence between how the individual experiences or expresses his or her gender and that individual’s assigned gender (American Psychiatric Association 2013). In addition, rather than referring solely to the “other gender,” DSM-5 also refers to “some alternative gender,” encompassing gender spectrum identities.

Transgender Identity Formation

With the diversity of gender identities and expressions and differing life courses, generalizations about transgender identity formation are of limited value. Some children express gender nonconforming behavior in very early childhood, rejecting clothes and play traditionally associated with their sex assigned at birth. Some children exhibit aspects of both genders (Ehrensaft 2011). Although many gender nonconforming children do not become trans-identified adults and later may identify as gay or lesbian, some gender non-

conforming children have strong cross-gender identities and may socially transition in early childhood. Gender dysphoria of children in DSM-5, in a change from GID in children in DSM IV-TR, requires an indicator of cross-gender identity and not just gender nonconforming behavior in order to be diagnosed.

At the onset of puberty, Tanner stage II, children with persistent cross-gender identity may start puberty-blocking drugs, particularly gonadotropin-releasing hormone agonists. These drugs suspend development of secondary sex characteristics, giving the child more time to explore his or her gender identity (Delemarre-van de Waal and Cohen-Kettenis 2006). If the adolescent does eventually transition, intervening before development of secondary sex characteristics of the sex assigned at birth allows for better physical and emotional outcomes. Trans identity persisting into adolescence signals an adult trans identity, and clinics offering puberty blockers leading to treatment with sex hormones have demonstrated a very high success rate, with regret being very uncommon (Cohen-Kettenis et al. 2008).

Transgender adults may recall cross-gender behavior in childhood but may transition at any stage of life. Gender nonconformity may be suppressed during childhood, with family, peer, and societal disapproval internalized by the individual. Furtive cross-dressing or other manifestations of gender dysphoria may be present. Some individuals marry and have families before acknowledging their transgender identities, and some suppress their gender dysphoria until transitioning late in life, after children are grown or after retirement. On developing a conscious awareness of trans identity, some feel a tremendous pressure to transition. Social transition and early medical interventions (e.g., hormone therapy and, for trans men, chest surgery) may provide tremendous relief of gender dysphoria early in the process of transition.

Transition Care and the WPATH Standards of Care, Version 7

The Standards of Care, Version 7 (SOC 7), of WPATH, released in 2011, reflect changing conceptions of transgender care. SOC 7 states that the distress of gender dysphoria, not transgender identity, is the illness and focus for treatment and that people with a spectrum of identities can present with gender dysphoria (Coleman et al. 2011).

Prior versions of the SOC had been criticized for limiting access to hormone therapy with requirements for psychotherapy or at least 12 weeks of living in the “opposite gender role” and with the “gatekeeping” role of evaluations by mental health professionals. Starting in the early 1990s, the Tom Waddell Health Center in San Francisco, California, and some urban primary care centers in the United States started providing hormone therapy using an informed consent model similar to that used in consenting to other medical treatment (Davidson et al. 2013). In this model, experienced primary care providers can prescribe hormones for patients with gender dysphoria who have the capacity for informed consent and understand the risks and benefits of treatment, without an evaluation by a mental health professional. A thorough explanation of the risks and benefits of hormone treatment by the provider and an assessment of the patient’s understanding of benefits and risks of treatment are necessary. Risks include not only potential side effects of medication but also psychosocial risks of transition. For example, if the patient is dependent on family or a partner for housing or financial support, is there a plan if transition affects the relationship? If co-occurring substance use disorder or other mental illness is identified in the assessment, appropriate care or referrals must be available. Clinics now use this model successfully across the United States (Deutsch 2012).

The informed consent model is supported by the SOC 7. A mental health professional with knowledge and experience in transgender care can provide a referral letter to the hormone prescriber on the basis of the presence of persistent gender dysphoria and the capacity to give informed consent. Mental health concerns should be “reasonably well-controlled,” but the SOC 7 also allows for the simultaneous treatment of gender dysphoria, substance use disorder, and other mental illness. Under the SOC 7, primary care providers experienced in trans care can also make the assessment of persistent gender dysphoria and the capacity for informed consent but must refer patients to mental health professionals when indicated (e.g., co-occurring substance use disorder or other mental illness).

The SOC 7 requires one mental health evaluation for chest surgery and two for genital surgery, with the following requirements: persistent gender dysphoria that would benefit from surgery; the ability to give informed consent; and that co-occurring mental illness, if present, is well controlled. Chest surgery for trans men may be an early step in transition, facilitating their ability to live in the male social role. For vaginoplasty, metoidioplasty, and phalloplasty, the patient must

live stably for 1 year in the gender in which he or she plans to live postoperatively, on hormone therapy unless contraindicated. As access to surgery for low-income people expands, there is increased focus on the importance of stable housing and practical support postoperatively while the patient heals.

Transgender Patients in Health Care Settings

Transgender people often delay seeking medical help because of negative experiences (or fear of them) in health care settings, according to the National Transgender Discrimination Survey Report on Health and Health Care (Grant et al. 2010). Transgender people often are refused health care and have difficulty finding knowledgeable providers—half reported having to teach their health care providers about transgender care.

Transgender people arrive at health care settings with long histories of trauma related to gender identity and expression. In a survey by Grant and colleagues (2011) of more than 6,000 trans people, 78% had been harassed at school, and 47% suffered job discrimination. Many had been victims of physical or sexual assault, and 41% reported a suicide attempt.

In keeping with principles of cultural humility in the care of transgender patients, the psychiatrist caring for the transgender patient should follow the patient's lead in use of pronouns and preferred names. The psychiatrist should be knowledgeable in transgender care but resist imposing his or her narrative of gender transition on the patient. Rather, the psychiatrist should allow patients room to explore their identity. The Cultural Formulation Interview (CFI) and its supplementary module 6, "Cultural Identity," can offer some guidance here. Questions 8–10 of the CFI open up the discussion of the individual's cultural identity (see Appendix 1, "DSM-5 Outline for Cultural Formulation, Cultural Formulation Interview, and Supplementary Modules" p. 483).

CFI supplementary module 6, "Cultural Identity," can be particularly helpful in eliciting a gender identity. The clinician can start with questions about national origin, grandparents, ethnic background, how patients would describe themselves to others, which parts of their identity they resonate with, experiences with discrimination, and how their identity affects their health care (questions 1–7). Questions 26–28 and the introduction to the section "Gender Identity" are very helpful in eliciting a gender identity (see Appendix 1, p. 504).

A more detailed exploration of gender identity is important with patients presenting with gender dysphoria or seeking care for other symptoms related to gender transition. This evaluation should include open-ended questions related to gender and transition, without imposing a preconceived narrative. The patient should be asked about discomfort with physical aspects of his or her body and about expectations for physical changes with transition. If there is discomfort with his or her socially expected gender role, what is the desired social gender role and perception by others? Current gender nonconforming behaviors (e.g., cross-dressing) and association with gender dysphoria should be discussed. The interaction of sexuality with gender identity should be explored, including sexual fantasy and comfort or discomfort with genitals during sex. Social support and the coming out process should be discussed. Has the patient revealed his or her transgender identity to others, and if so, what has that experience been like? Is there support from family, friends, and the community, or does the patient feel unsafe? How might transition affect relationships, employment, and housing?

Gender identity and expression across the lifespan should be explored, including childhood nonconformity, gender identity and dysphoria with puberty and adolescence, and effects of gender nonconformity on family and peer relationships and school performance. How have gender identity, expression, and dysphoria changed with aging? The patient should be asked about past efforts to transition and their consequences, as well as whether there has been associated trauma, depression, anxiety, or substance use (Bockting et al. 2006).

Health care providers should recognize that transgender patients may have suffered discrimination by medical and other authorities and may be survivors of trauma. In health care settings, a welcoming environment can be supported by training ancillary staff on addressing patients with appropriate names and pronouns and supporting policies so that patients can access clinic restrooms and patient groups in their identified gender.

The following case illustrates principles of culturally sensitive care for transgender patients, with discussion in the form of the DSM-5 Outline for Cultural Formulation. In describing the case, gendered pronouns are not used until the patient identifies as female. The clinician should ask patients their preferred name and pronoun; in some cases, neither male nor female pronouns are appropriate. Genderqueer patients and others with gender spectrum identities may use non-traditional pronouns (e.g., “they” and “their” as nongendered singular pronouns).

Case 1

A. is a 19-year-old African American, assigned male at birth, who identifies as neither male nor female. A. was referred by a psychotherapist to the Dimensions Clinic, which serves gender nonconforming and trans adolescents and young adults in San Francisco, California. A. presented considering hormone therapy. A. believed that their body and facial features were becoming too masculine with age. A. had intense discomfort with male genitalia and libido but wanted a flat chest.

The patient reported dropping out of university because of mood swings and heavy drinking. After a period of homelessness, A. now works intermittently to pay rent but spends much of their time at home, drinking up to 750 mL vodka plus wine every day.

On examination, A. reported several days with periods of edginess, racing thoughts, and insomnia alternating with periods of depression, hopelessness, fatigue, and suicidal thoughts. A. has no history of past psychiatric treatment. A. reported preferring childhood play with girls and being perceived as feminine. A.'s father, who was in and out of prison, was physically and emotionally abusive, especially with regard to A.'s perceived femininity as a child. A. had a good relationship with their mother. A. identifies as bisexual and was dating a trans man on initial visit.

A. was diagnosed with bipolar II disorder and alcohol use disorder, and treatment with mood stabilizers was initiated. A. was encouraged to address their alcohol use disorder. A. was not interested in sobriety but agreed to reduce use and addressed alcohol use in psychotherapy. A. did not attend 12-step meetings. Sobriety was not a precondition for hormones, but A. was informed that the primary care physician would not initiate hormonal treatment for gender dysphoria if their liver enzymes (aspartate aminotransferase and alanine aminotransferase) were elevated, which motivated A. to reduce drinking.

A. attended multiple weekly sessions with a psychotherapist as well as several sessions with a psychiatrist to stabilize psychiatrically and determine the best course of gender treatment. A. wanted a flat chest and "flat" genitalia, feeling this was most consonant with their gender identity. A. was started on spironolactone, an antiandrogen, which provided some relief from an uncomfortable libido. A. then agreed that the breast growth that would occur with estrogen therapy was an acceptable trade-off for the desired feminizing of other body features and further suppression of libido. Low-dose, and later full-dose, estradiol was added to A.'s medication regimen.

Estradiol and spironolactone reduced A.'s libido and discomfort with masculine features. Her appearance continued to feminize with time. A. legally changed her name to a different male name with a female middle name

and a new surname and preferred to be called by an androgynous shortening of her last name. Although A. continued to identify as genderqueer rather than male or female, she felt that female was a closer approximation of her gender identity and started using female pronouns and a feminine pronunciation of her first name. A. changed the gender on her driver's license to "F." California, as well as some other states and some provinces in Canada, the U.S. federal government, and many other nations, now allow legal gender change on all identity documents without surgery.

A. completed a prestigious internship presenting as male, receiving some comments from coworkers about androgyny and breast growth. On return to school, A. was comfortable presenting as female and was in a stable, supportive relationship. A. continued to drink, in relative moderation, and her mood remained stable on medication.

Two years later, A. returned for psychiatric consultation on medications, and her mood-stabilizing medication was changed. A. presented as female, but her identity remained genderqueer. A. was married and working full-time. Her drinking remained moderate, and it did not interfere with her functioning.

Three years later, A. returned seeking genital surgery, which was now provided in San Francisco for low-income people. Her bipolar disorder was well controlled with lithium. She reported binge drinking about once a week. Her presentation was female, but A. still identified as genderqueer. A. was seeking a "flat" genital area, with severe dysphoria about her penis, consistent since initial presentation. She stated she would prefer penectomy with orchiectomy but would accept vaginoplasty if that were all that was available. She stated that she was not interested in the preservation of sensation and that her sexual arousal was nongenital. A. stated that her spouse was supportive of her deciding on the desired surgery. She continued to work full-time, had stable housing, and could be assisted postsurgery by her husband.

Case Discussion: Outline for Cultural Formulation

Cultural Identity of the Individual

A. identifies as African American and was raised in a lower-income urban neighborhood. A.'s father was absent for periods because of incarceration and when present was not accepting of feminine traits in his child. A.'s mother was generally supportive. A.'s perceived femininity led to bullying by peers. As a young adult, A. found support in a more accepting community with many gender nonconforming and transgender peers. This community included

others supportive of gender spectrum expression and identity. This community was also permissive of A.'s heavy drinking. A.'s name change, to another male name and a female middle name, and a new last name, represented a separation from A.'s past, with rejection of her father's surname.

Cultural Conceptualizations of Distress

A. reported gender nonconforming behavior in childhood and gender dysphoria in adolescence but was raised in a culture that rejected, sometimes violently, expressions of femininity in boys. As a young adult, A. found a community supportive of genderqueer and trans identities. Hormone therapy was necessary to reduce A.'s intense dysphoria about male body characteristics. However, A. was still able to present as male in an internship that was less accepting of gender nonconformity, and in this way, an in-between state was adaptive. A. identified as neither male nor female, but over time found "female" a better approximation of identity than "male" when needing to make a binary choice, as with a driver's license.

A. rejected sobriety and Alcoholics Anonymous, viewing alcohol use as both self-medicating and an important connector with social supports. A. used alcohol intoxication to cope with the intense discomfort of gender dysphoria, as well as to cope with mood symptoms. With the reduction of gender dysphoria with hormone therapy and treatment of A.'s bipolar disorder with mood stabilizers, A. was able to greatly reduce her alcohol consumption.

Psychosocial Stressors and Cultural Features of Vulnerability and Resilience

Because of her history of being bullied for perceived femininity, A. suppressed feminine expression, intensifying her gender dysphoria. However, the development of a social network of gender nonconforming people and other accepting young adults facilitated A.'s ability to successfully transition. Psychosocial stressors included financial stress, at times tenuous housing, and the perceived necessity to present as male during an internship while transitioning socially and medically. Gender nonconforming people are much more likely to be subjected to harassment, discrimination, and violence. A.'s resilience was demonstrated in her ability to reach her goals in education, occupation, and relationships, including marriage. This resilience and current

psychosocial stability (with income, housing, and support from spouse) can aid in a good postoperative outcome.

Cultural Features of the Relationship Between the Individual and the Clinician

A. is a transgender African American individual of differing age and socioeconomic and educational background from her psychiatrist, psychotherapist, and primary physician, all of whom are white and cisgender (identifying with their sex assigned at birth). However, A. felt connected to the clinic and its staff and remained engaged in care. A. felt comfortable expressing her nonbinary gender identity and in communicating mood symptoms and alcohol use. The psychiatrist did not impose a binary narrative on A.'s transition and was supportive of A.'s attempts to navigate outside systems that are based in binary conceptions of gender. For example, when A. changed her name to another male name with a female middle name and a last name different from her father's, she needed a new driver's license for identification. The psychiatrist filled out the form verifying gender transition to female as requested by A., although A.'s first name was male and her appearance was androgynous at the time.

Some clinicians would insist on stabilization of A.'s psychiatric and substance use disorders before addressing gender transition, but addressing all of these issues simultaneously helped keep A. engaged in care. Hormone therapy and psychotherapy for gender dysphoria helped with mood stabilization and reduction of alcohol abuse. Mood stabilizers further helped A. reduce her alcohol use and helped her pursue gender transition and career and personal goals.

A. was seen at the Dimensions Clinic, a specialty clinic of the San Francisco Department of Public Health focused on gender nonconforming and transgender adolescents and young adults. The clinic employs transgender and multicultural staff, and all staff are trained in culturally sensitive care. Most staff are bilingual in English and Spanish. Staff are expected to address patients by their preferred names and pronouns, despite challenges with electronic health records systems that were not developed with trans patients in mind. Patients may choose which bathroom to use, men's or women's. The Dimensions Clinic operates at separate times from other clinics at the Castro-Mission Health Center, so the waiting room is a welcoming and supportive environment. Support groups, individual psychotherapy, substance abuse

counseling, psychiatric care, and primary care are available from providers knowledgeable in the care of trans youth. Even in this supportive environment, establishing trust and safety can be challenging when patients have suffered harassment and abuse, including in other medical settings, and providers must be aware that patients' past negative experiences may affect their interactions with clinic staff.

Overall Cultural Assessment

A. is an African American genderqueer young adult seen for transition-related care, as well as treatment of bipolar II disorder and alcohol use disorder, in a multidisciplinary public health clinic specializing in the care of transgender youth. A. is estranged from her father and others in her community of origin as a result of abuse and bullying in childhood. In a supportive clinic environment and a more supportive community, A. was able to explore her gender identity and transition hormonally and socially while still identifying as genderqueer. She is seeking genital surgery to further reduce gender dysphoria and have a body more consonant with her gender identity. A.'s gender dysphoria, bipolar disorder, and alcohol use disorder have responded well to treatment, with greatly reduced distress and much improved social and occupational functioning. Treating A.'s gender dysphoria, bipolar disorder, and substance use disorder simultaneously, while not imposing a binary gender transition narrative, helped this patient successfully navigate the challenging experience of gender transition.

Conclusion

Trans patients present the clinician with the opportunity to evaluate patients on the basis of their gender identity, which may not match their assigned birth gender or physiological gender. With the new changes to DSM-5, including the diagnosis of gender dysphoria, and advances in the standards of care for the medical and surgical management of transition, mental health professionals can provide needed services for the trans population that are nonjudgmental and supportive of the individual's gender identity developmental stage. The CFI and its "Cultural Identity" supplementary module 6 can offer valuable guidance in how to evaluate a patient's gender identity.

References

- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000
- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Washington, DC, American Psychiatric Association, 2013
- Bakker A, van Kesteren PJ, Gooren LJ, et al: The prevalence of transsexualism in the Netherlands. *Acta Psychiatr Scand* 87(4):237–238, 1993
- Bockting WO, Knudson G, Goldberg JM: Counseling and mental health care for transgender adults and loved ones. *Int J Transgend* 9(3/4):35–82, 2006.
- Clements-Nolle K, Marx R, Guzman R, et al: HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: implications for public health intervention. *Am J Public Health* 91(6):915–921, 2001
- Cohen-Kettenis PT, Delemarre-van de Waal HA, Gooren LJG: The treatment of adolescent transsexuals: changing insights. *J Sex Med* 5:1892–1897, 2008
- Coleman E, Bockting W, Botzer M, et al: Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7. *Int J Transgend* 13:165–232, 2011
- Conron KJ, Scott G, Stowell GS, et al: Transgender health in Massachusetts: results from a household probability sample of adults. *Am J Public Health* 102(1):118–122, 2012
- Davidson A, Franicevich J, Freeman M, et al: Tom Waddell Health Center Protocols for Hormonal Reassignment of Gender. San Francisco, CA, Tom Waddell Health Center, 2013. Available at: <http://www.sfdph.org/dph/comupg/oservices/medSvs/hlthCtrs/TransGendprotocols122006.pdf>. Accessed January 28, 2014.
- Delemarre-van de Waal HA, Cohen-Kettenis PT: Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects. *Eur J Endocrinol* 155(1):131–137, 2006
- Deutsch MB: Use of the informed consent model in the provision of cross-sex hormone therapy: a survey of the practices of selected clinics. *Int J Transgend* 13(3):140–146, 2012
- Dhejne C, Lichtenstein P, Boman M, et al: Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. *PLoS One* 6(2):e16885, DOI: 10.1371/journal.pone.0016885, 2011
- Dhejne C, Öberg K, Arver S, et al: An analysis of all applications for sex reassignment surgery in Sweden, 1960–2010: prevalence, incidence, and regrets. *Arch Sex Behav* May 29, 2014 [Epub ahead of print]

- Ehrensaft D: *Gender Born, Gender Made: Raising Healthy Gender-Nonconforming Children*. New York, Experiment, 2011
- Fraser L, Karasic DH, Meyer WJ, et al: Recommendations for revision of the DSM diagnosis of gender identity disorder in adults. *Int J Transgend* 12(2):80–85, 2010
- Grant JM, Mottet LA, Tanis J, et al: *National Transgender Discrimination Survey Report on Health and Health Care*. Washington, DC, National Center for Transgender Equality, 2010. Available at: http://transequality.org/PDFs/NTDSReportonHealth_final.pdf. Accessed January 28, 2014.
- Grant JM, Mottet LA, Tanis J, et al: *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. Washington, DC, National Gay and Lesbian Task Force, 2011. Available at: http://www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf. Accessed January 28, 2014.
- Kuyper L, Wijzen C: Gender identities and gender dysphoria in the Netherlands. *Arch Sex Behav* 43(2):377–385, 2014
- Sausa LA, Sevelius J, Keatley J, et al: *Recommendations for Inclusive Data Collection of Trans People in HIV Prevention, Care & Services*. San Francisco, Center of Excellence for Transgender Health, University of California, 2009. Available at: <http://transhealth.ucsf.edu/trans?page=lib-data-collection>. Accessed January 20, 2014.
- Vance, SR, Cohen-Kettenis PT, Drescher J, et al: Opinions about the DSM gender identity disorder diagnosis: results from an international survey administered to organizations concerned with the welfare of transgender people. *Int J Transgend* 12(1):1–14, 2010

Religious and Spiritual Assessment

David M. Gellerman, M.D., Ph.D.

The United States is home to a diversity of religious faiths (Koenig 2007; Richards and Bergin 2005); many Americans endorse a belief in God; pray; and regularly attend a church, temple, or other religious institution. Religious and spiritual belief systems and faith communities are important means of maintaining traditions, including culturally held values, social behavior, and meaning (Pulchaski 2006; Shafranske 1992). In addition, a patient's spiritual or religious faith may play an important role in medical decision making, such as considering blood transfusions, organizing an advance directive, or determining do-not-resuscitate status (Koenig 2007; Lo et al. 2002). Spiritual issues can become particularly important when patients are facing terminal illness and hospice care (Block 2001; Lo et al. 2002). Interested readers are en-

couraged to examine Koenig's (2007) *Spirituality in Patient Care: Why, How, When and What* for a more detailed discussion about incorporation of spirituality in the medical care of patients.

In the past two decades, the importance of religious faith and spirituality in medical patients has been increasingly recognized, such that addressing spirituality in medical education and care is mandated by several institutions, including The Joint Commission (formerly known as the Joint Commission on Accreditation of Healthcare Organizations [JCAHO]) (Koenig 2007; Pulchaski 2006). Furthermore, the Accreditation Council for Graduate Medical Education's (ACGME) "Program Requirements for Residency Training in Psychiatry" mandates teaching of cultural and religious factors that may influence psychological development as part of the core competency in medical knowledge (Accreditation Council for Graduate Medical Education 2007).

The inclusion of the Outline for Cultural Formulation (OCF) and culturally relevant information was a progressive step in DSM-IV (American Psychiatric Association 1994) and its text revision, DSM-IV-TR (American Psychiatric Association 2000, Appendix I, pp. 897–898), and the update in DSM-5 (American Psychiatric Association 2013, pp. 749–750). Examples of increasing sensitivity to cultural variations in DSM-5 are included in the "Culture-Related Diagnostic Issues" and "Gender-Related Diagnostic Issues" sections of the narrative descriptions of some mental disorders. Use of the OCF may increase the awareness of heterogeneity within (sub)cultural and ethnic groups (Lewis-Fernández and Díaz 2002), such that even when no obvious cultural differences are seen between a patient and a clinician, the OCF may detect hidden assumptions and biases by the clinician. The American Psychiatric Association's *Practice Guidelines for the Psychiatric Evaluation of Adults*, 2nd Edition, incorporates the OCF, specifically commenting on potential cultural, religious, and spiritual factors that may be important to consider in psychiatric assessments (American Psychiatric Association 2006a).

In this chapter, I describe strategies to perform a spiritual and/or religious assessment as a routine part of the psychiatric interview, use of the OCF to incorporate this information as part of the clinician's understanding of the patient, and potential results and interventions from having such information. Although the meanings of *spiritual* and *religious* differ, these terms are used interchangeably for the purposes of this chapter.

Performing a Spiritual Assessment

Considering the limited time available to clinicians, the spiritual history must be direct and brief, providing sufficient information to determine whether more time and details are required. In general, a spiritual history allows patients an opportunity to discuss their religious or spiritual beliefs, values, and practices; how these may influence or affect their medical decision making or treatment goals; and potential sources of religious or spiritual strength or concern (Lo et al. 2002; Pulchaski 2006).

When incorporating a spiritual history into routine history and physical examinations, Pulchaski (2006) recommends including it as a part of the social history because this would include inquiry into the patient's living situation and relationships. The spiritual history can be included as part of a series of questions about lifestyle, such as diet, exercise, and coping with stress. Another opportunity to incorporate a spiritual history is during a suicide risk assessment, as seen in the following case (see also Case 2 from Chapter 7, "Cultural Issues in Women's Mental Health").

Case 1 (Video 6)

Ms. Diamond is a 38-year-old single Jewish American woman from Trumbull, Connecticut, who is living in Manhattan and working as a legal secretary. She came in for treatment of depression that she has had for many years, stating that she is depressed and not happy. She reports chronic unhappiness, starting from her teenage years, with poor self-esteem and body image. Ms. Diamond also has problems with fatigue and insomnia, falling asleep at 2:00 A.M. and sleeping only 2–3 hours per night. She finds her work "annoying," sees extra work as an imposition on her time, and calls in sick at least once a month. She does not take vacations anymore because they are "too much of a hassle." She has been in treatment for many years with four or five different therapists, including group therapy, at ages 16, 20, and 25 but remains irritable, sad, guilty, and lonely. Her last therapist was a Jewish woman, who understood her well but retired abruptly, according to the patient, after 3 years of treatment, and she is looking for a new therapist.

When the interviewer asks, "No thoughts of suicide?" Ms. Diamond replies, "It's way against my religion." The interviewer takes this opportunity to explore the patient's religious and spiritual upbringing, beliefs, and practices (see Video 6–1). As illustrated in the video, patients may give clinicians cues to explore their religious identity in the context of other questions. Clinicians

should use those opportunities to ask the patient to say more about his or her spirituality.



Video Illustration 6–1: Cultural identity and religion (3:55)

The role of religious and spiritual factors in assessing suicide may be especially important because many religions discourage or prohibit suicide (Gearing and Lizardi 2009). Among elderly African American residents of public housing developments in Baltimore, Maryland, measures of social support and religiosity were negatively associated with suicidality and passive wishes to be dead (Cook et al. 2002). In a study of depressed patients in hospitals, those patients endorsing religious affiliation were less likely to have a history of suicide attempts and suicidal ideation, even when the severity of depression was controlled for, largely mediated by greater moral objections to suicide (MOS), as measured with the MOS subscale of the Reasons for Living Inventory, whose items largely reflect traditional Western religious beliefs (Dervic et al. 2004). A similar finding was reported among inpatients diagnosed with depression and reporting a history of childhood abuse (Dervic et al. 2006). Depressed inpatients with lower MOS scores were found to have a greater number of lifetime suicide attempts and less often endorsed religious affiliation compared with inpatients with higher MOS scores (Lizardi et al. 2008).

In a national study across Canada, endorsement of spirituality was associated with decreased odds of suicide attempts, and religious attendance was associated with reduced odds of both suicidal ideation and suicide attempts; however, only the relationship between religious attendance and suicide attempts remained significant when measures of social support were removed, suggesting that protective effects of spiritual factors may be mediated by social support (Rasic et al. 2009). Although the research in spiritual and religious factors in suicide is complicated by use of a variety of measures to operationalize these constructs, the proposed differences between *spirituality* and *religiousness*, and the cross-sectional design of many of the studies, among other confounds (Colucci and Martin 2008), in general, endorsement of religious factors appears to be associated with lower rates of suicidal ideation, greater negative attitudes toward suicide, and, to a degree, fewer suicide attempts.

Therefore, the clinician should always ask about religion and spirituality when assessing a patient's risk for suicide.

Koenig (2007) summarized several tools to help obtain a spiritual history. For example, FICA is a mnemonic to inquire into or listen for patients' Faith and beliefs, the Importance of religious or spiritual life in regard to patients' medical care, whether patients are part of a religious or spiritual Community, and how to Address spiritual issues in the patients' care, if appropriate (Pulchaski 2006) (see Table 10–1). Other tools include SPIRIT (Maugans 1996), inquiring into Spiritual beliefs, Personal spirituality, Integration with a spiritual community, Rituals, Implications for medical care, and Terminal events planning (e.g., advance directives), and HOPE (Anandarajah and Hight 2001), in which the clinician asks about sources of Hope, Organized religion, Personal spirituality, and Effects on medical care. Some patients might not endorse having a religious or spiritual faith; even so, clinicians could use the OCF to inquire into patients' coping strategies when in distress and sources of meaning in their lives. In the example, in Video 6–1, the interviewer takes the opportunity to explore the patient's religious and spiritual experiences by asking, "How much of a part of your life growing up was your Jewish faith?" In the interview, the patient describes her Jewish faith as a central part of her values growing up but also as a source of stress and discrimination from anti-Semitism.

Koenig (2007) suggests incorporating a spiritual history during new patient evaluations, hospital admissions, and routine health maintenance visits and reviewing the spiritual history if significant changes in patients' health or social circumstances occur. Patients may immediately identify their faith or religion as the primary means of coping with illness and stress. Others may indicate their family or other relationships. Patients may state that their faith can be a source of stress or that their usual attendance at church or temple has changed, in which case patients may be invited to elaborate. Recent changes in a patient's perceived religiosity, faith, or church attendance may indicate depression or other mental health disorders. Patients identifying religious or spiritual concerns could be encouraged to seek counseling or should be referred to clergy, pastoral services, or chaplaincy, as appropriate.

Table 10–1. Mnemonics for a spiritual assessment

FICA

Faith and beliefs

Importance of religious or spiritual life in regard to the patient's medical care

Community: Does the patient have one?

Address spiritual issues in the patient's care

SPIRIT

Spiritual beliefs

Personal spirituality

Integration with a spiritual community

Rituals

Implications for medical care

Terminal events planning (e.g., advance directives)

HOPE

Hope

Organized religion

Personal spirituality

Effects on medical care

Source. Anandarajah and Hight 2001; Maugans 1996; Pulchaski 2006.

Case 2 (Video 3)

Mr. Jones is a 32-year-old married African American man who is a computer network administrator for San Francisco State University. His wife, Tina, is an African American lawyer working at her father's firm. Mr. Jones presents because a few weeks ago he forgot to pick up his daughter from day care because he was too tired. "I'm not acting like myself," he states. He describes his life as being "Mr. Mom." He has been feeling this way for at least a year, but he has felt worse in the last few months. His wife asked him to get help, and he asked her to make the appointment for him. He complains of fatigue and irritability and of people, including his supervisor, "buggin' me" to get his work done on

time. He states that his wife is a workaholic and that it is his job to pick up their 2-year-old daughter, Brittany, from day care because of his wife's unavailability during her 10- to 12-hour workdays. Her work schedule has significantly affected their relationship, and they rarely have sexual relations. They argue frequently. He complains of early-morning awakening, alternating with days when he has difficulty waking up.

In Video 3–2, Dr. Boehnlein explores Mr. Jones's religious background and upbringing and finds that Mr. Jones and his wife are from different faiths, Baptist and Catholic. His wife does not insist that their daughter be raised Catholic, and Mr. Jones brings his daughter to his Baptist church in Oakland, where he grew up.



Video Illustration 3–2: Spiritual assessment (2:37)

Inquiring into patients' religious and spiritual beliefs and practices and assessing sources of religious concern is not to suggest that clinicians act as spiritual care providers, even if the clinician and patient happen to share the same religious faith. Physicians are not trained to provide pastoral or spiritual care per se, although encouraging and supporting beliefs and practices already identified by the patient typically would not disrupt or impose on the clinician-patient relationship (Koenig 2007; Pulchaski 2006). With practice, care, and respect, carefully avoiding proselytizing or prescribing new religious or spiritual behaviors, clinicians can become increasingly comfortable with obtaining spiritual histories, adding minimal time to the appointment (in Case 2 from Chapter 7, the formal spiritual and religious history took about 5 minutes but became a salient theme for the rest of the interview) and potentially contributing to the physician-patient relationship.

Using the Outline for Cultural Formulation to Organize the Spiritual Assessment

As described in DSM-5, the updated OCF contains five categories of information that may be important in clinical care: 1) the cultural identity of the individual, 2) cultural conceptualizations of distress (formerly cultural explanations of the individual's illness), 3) psychosocial stressors and cultural features of vulnerability and resilience (formerly cultural factors related to the psychosocial environment and levels of functioning), 4) cultural features (elements) of the

relationship between the individual and the clinician, and 5) overall cultural assessment (American Psychiatric Association 2013).

Cultural Identity of the Individual

The influences of various cultural and ethnic groups on the individual's sense of self as well as self-described affiliations are documented and described in this category. Religion and spirituality often offer meaning and purpose to an individual's life, and religious faith or spiritual affiliation can be an essential part of one's individual identity. In the past two decades, the importance of religious faith and identity in medical and mental health patients has been increasingly recognized.

Although the United States is predominantly a Christian country, it is also home to a diversity of religious faiths (Koenig 2007; Richards and Bergin 2005). Many Americans endorse a belief in God; pray; and regularly attend a church, temple, or other religious institution. Religious and spiritual belief systems and faith communities can play an important part in transmitting culturally held values, social behavior, and meaning even in early stages of psychological development (Shafranske 1992). Such beliefs and values may be challenged when one's perceived identity is threatened or distorted at times of crisis or transition (Peteet 2004), contributing to one's suffering.

Additionally, conflicts may exist between one's spiritual or religious identity in the context of one's minority status. For example, many Western mainstream religions may discourage, forbid, or even oppress homosexuality, but several studies have refuted the suggestion that gay and lesbian individuals may suffer from being "spiritually impoverished." Tan (2005) examined the "religious well-being" and "existential well-being" of 93 gay and lesbian individuals in the American Midwest and found that respondents endorsed high levels of both, whereas high existential well-being predicted higher self-esteem, lower internalized homophobia, and lower endorsements of alienation. The study by Tan (2005) was limited by a small sample size, a cross-sectional design, and selection bias, but it suggested that gay and lesbian individuals can identify themselves as having rich spiritual and religious lives. García et al. (2008) reviewed the challenges faced by gay, bisexual, and transgender individuals in the United States whose homosexual identity conflicts with their religious upbringing and faith, especially among Latino men raised Catholic. García et al.

(2008) performed semistructured life history interviews with 80 Latino gay, bisexual, and transgender men in both Chicago, Illinois, and San Francisco, California, of whom 66 were raised Catholic during childhood. Those individuals who moderately or highly participated in and were committed to the Catholic faith as children continued to identify as Catholic as adults (26 of 66), whereas the remaining participants with lower participation and commitment as children had left the Catholic Church as adults. Despite endorsing conflict between their sexual orientation and Catholicism, all gay, bisexual, and transgender men described reconciling their religious faith and their sexuality to some degree, whether they remained Catholic, converted to another faith, or did not identify any formal religious or spiritual affiliations, although several in the last group described continuing to believe in God, pray, or read books on spiritual development. Again, despite potential conflict between mainstream religions' stance on homosexuality, many lesbian, gay, bisexual, and transgender individuals endorse religious or spiritual beliefs and practices as an important part of their identity. See Chapter 8, "Sexual Orientation," for more aspects of gay and lesbian identity.

It is important to remember that one's religious or spiritual identity may also be subject to change in response to significant events in one's life. For example, the experience of trauma in individuals with posttraumatic stress disorder (PTSD) was more likely to predict changes in spiritual or religious beliefs compared with individuals without PTSD (Falsetti et al. 2003). In this study, of the group meeting criteria for PTSD, 30% described becoming less religious after trauma, compared with only 6% of the non-PTSD group. Additionally, 20% of the PTSD group described an increase in their religious faith, compared with 9% of the non-PTSD group. Fontana and Rosenheck (2004) studied more than 1,000 combat veterans who were evaluated for PTSD, many of whom had endorsed religion as a "source of comfort" prior to service in the military. Of the combat veterans, 24% reported that religion had become a greater source of comfort, but 29% indicated the opposite. Thus, although religious or spiritual faith may be used as a source of coping with trauma, the experience of trauma and development of PTSD can also affect the degree to which patients consider themselves religious or spiritual.

Neeleman and Lewis (1994) examined the religious and spiritual beliefs and attitudes of several groups of psychiatric patients compared with nonpsychiatric control subjects. Patients with psychiatric disorders identified them-

selves as religious and placed importance on religious faith significantly more than did the nonpsychiatric control subjects. Baetz et al. (2002) examined religious and spiritual commitment in 88 patients admitted to a psychiatric hospital, most of whom had been diagnosed with a major depressive episode. They found that the frequency of worship attendance and intrinsic religiousness were significantly correlated with lower depressive symptoms at the time of admission. In addition, these variables were negatively related to current and lifetime alcohol abuse. In a qualitative study of outpatients with psychotic illnesses, 85% endorsed that religion was important in their lives, being “most important” in almost half of the participants (Mohr et al. 2006). Most participants in the study endorsed that their religious faith was important in giving meaning to their lives and to their illness, attributing their ability to cope and gain some control in their lives to their faith. Huguelet et al. (2006) interviewed 100 Swiss outpatients with a primary psychotic disorder about spiritual and religious coping. They found that although a majority (77%) rated the significance of spirituality in their daily life as “important” or higher, only 38% of these patients had raised the topic with their clinicians; in addition, few clinicians were able to accurately describe their patient’s spiritual or religious participation. This study reiterates not only the potential value and importance of spirituality or religious faith for psychiatric patients but also the relative ignorance of clinicians about this important area in their patients’ lives.

After screening patients to determine whether their religion or spirituality is an important facet of their lives and potentially of their medical care, further exploration is encouraged. For example, clinicians may ask patients how their ethnicity or sexuality has played a role in their religious or spiritual lives and vice versa. Furthermore, asking whether a patient’s faith or spirituality has changed over time may give clues to key life experiences, such as in the development of a patient’s sexuality or the experience of trauma. While exploring these issues, it is important for clinicians not to assume how patients will answer; as the literature described earlier indicates, the relationships between developmental and traumatic experiences and one’s religious or spiritual life are complex.

Cultural Conceptualizations of Distress and Help-Seeking Pathways

This category asks the clinician to explore cultural factors that contribute to the patient's and family's experience and understanding of illness, such as idioms of distress and explanatory models. Such factors affect not only the relationship between the clinician and the individual and family and hence the diagnosis and treatment but also the relationships between the patient and the family and community at large. This section includes beliefs about causation of suffering; perceived severity and impairment; and help-seeking choices, preferences, and expectations regarding treatment. The individual or family may describe or explain the illness experience from a religious or spiritual framework, in which case the clinician may wish to assess for the possible diagnosis of a religious or spiritual problem.

Pargament et al. (2000) considered various ways that patients use religious or spiritual beliefs to find meaning in times of suffering or illness. For example, *benevolent religious reappraisal* describes interpreting a stressor or an illness as a potentially valuable spiritual experience, *punishing God reappraisal* strategies interpret stress and suffering as a punishment from God, and *demonic reappraisal* strategies attribute suffering to the devil or an evil entity. Religious and spiritual beliefs do not have to be thought of as mutually exclusive with secular explanations of illness. A patient diagnosed with hepatitis C and in need of interferon treatment may understand and accept that infection was likely a result of sharing intravenous needles but at the same time understand and believe that the infection was a punishment from God. Such patients may also seek comfort and counseling from their religious or spiritual leaders in the community or the chaplaincy services of a health care organization in addition to, or even prior to, seeking help from health care professionals.

Within the United States, clergy have been described as de facto mental health counselors for some individuals, offering a significant amount of time providing pastoral counseling (Weaver 1998). A study of 99 pastors of the African American clergy in metropolitan New Haven, Connecticut, found that participants averaged more than 6 hours per week doing pastoral counseling, with 22 pastors, or just over 20%, spending more than 8 hours a week doing counseling (Young et al. 2003). In this study, two-thirds of the pastors endorsed counseling individuals who were suicidal or believed to be potentially

dangerous to others. In addition to religious or spiritual problems, grief, marital or family problems, and alcoholism and drug addiction were “very often” or “fairly often” encountered. Similarly, a study of Muslim imams in the United States found that 50% endorsed spending up to 5 hours a week doing counseling, and 30% endorsed spending 6–10 hours a week (Ali et al. 2005). After spiritual and religious problems, relationship or marital problems and parent-child concerns were described as “often” or “very often” reasons that individuals came for counseling. The investigators also inquired about changes in congregants’ needs for counseling after September 11, 2001; participants in the study indicated an increased need for counseling for either feared or actual discrimination, financial concerns, or anxiety. However, in a study of African American women who had experienced an abusive relationship, many described being disappointed by the advice of Christian clergy, who recommended that they remain in the relationship or try harder to be a “good wife” (Potter 2007). Religious values can also be manipulated to encourage domestic violence and disrupt psychiatric care, as described by Stotland (2000) in her case report.

In addition to the questions proposed by Kleinman mentioned in Chapter 1, “Assessment of Culturally Diverse Individuals” (Table 1–8), clinicians should ask patients to what degree their faith, spirituality, and community are a source of strength or a source of stress on their health or when ill. How do their religious or spiritual lives contribute to the meaning of illness, and from whom do they seek help?

Psychosocial Stressors and Cultural Features of Vulnerability and Resilience

The psychosocial environment includes both stressors and supports related to the patient’s cultural background. Religious beliefs and practices can be one of several important factors contributing to a patient’s ability to cope with psychosocial stressors as explicitly stated in this section of the OCF (American Psychiatric Association 2000).

An early study of religious coping strategies in medical illness used the three-item Religious Coping Index, which includes an open-ended item on coping as well as specifically asking the degree to which one uses religion or spirituality as a means to cope (Koenig et al. 2001). When the index was administered to hospitalized veterans and patients in an academic hospital, 20%

of the veterans and 42% of the patients in the academic hospital spontaneously reported that religious beliefs and practices were “most important” to enable coping. Seventy percent of the veterans and 90% of the private hospital patients endorsed “moderate” use of religion to help cope in general, and 55% and 75%, respectively, indicated that religion was used to more than a “large extent” to cope with illness. In both self-rated and observer-rated depression scores in a veteran population, religious coping was inversely correlated with depressive symptoms. More interesting, the extent of the use of religion to cope predicted lower depressive scores 6 months later in a follow-up study of 201 readmitted patients. Considering the importance of religion and spirituality in coping with illness, a spiritual history may be an important part of an admission interview to assess sources of strength and coping as well as potential spiritual needs of hospitalized patients.

The degree to which religious coping strategies are effective or harmful for individuals has been studied extensively by Pargament et al. (2000). In cross-sectional studies examining the relationship between different means of religious coping and psychological adjustment to a variety of health stressors and trauma, some specific types of coping were found to be relatively healthy, whereas others appeared to be generally harmful. Examples of helpful or positive coping strategies included perceptions of spiritual support and guidance, congregational support, and attributions of negative life events to the will of God or a loving God, whereas negative coping strategies related to poorer outcomes included spiritual discontent, either with the congregation or with God, and perceiving negative life events as God’s punishment (Pargament and Brant 1998).

Negative religious coping strategies in the form of spiritual discontent and demonic reappraisal predicted greater mortality in hospitalized, medically ill elderly adults over a 2-year period, independent of variables related to demographics, physical and mental health, and church attendance (Pargament et al. 2001). In a related study, positive religious coping strategies were predictive of increases in stress-related growth, spiritual outcomes, and cognitive functioning at follow-up, whereas negative coping methods predicted declines in spiritual outcomes and quality of life, as well as increased depressed mood and decreased independence in daily activities (Pargament et al. 2004). Interestingly, some of the negative religious coping methods were related to improvements in health measures and declines in other measures, suggesting that the

relationships between spiritual coping and health care outcomes are more complicated than initially envisioned. Thus, some forms of religious coping may be protective and healthy, but some forms may contribute to poor spiritual and health outcomes. Such “religious struggle” could contribute to increased physical and psychological stress and social isolation (Pargament et al. 2001).

The roles of religion and spirituality among African American women enduring domestic violence have been examined by several studies. Most African Americans identify themselves as Christian (Miller 2007; Potter 2007), and participation in worship serves as not only a means of religious experience and establishing a sense of community but also a venue for speaking against oppression and seeking social justice and freedom (Miller 2007). Watlington and Murphy (2006) found that African American women with higher self-reported levels of spirituality and religious involvement had fewer depressive symptoms and that this relationship remained significant when variables related to abuse and socioeconomic factors were controlled for. However, only higher religious involvement, not spirituality, was associated with lower posttraumatic stress symptoms. In one study of 40 African American women who had experienced intimate partner violence (Potter 2007), relying on religious or spiritual faith to cope with the abusive relationship and eventually leaving the relationship was one of the most prevalent themes in a series of semistructured life history interviews. However, few women sought assistance from clergy to leave the abusive relationships, and as mentioned earlier, all of the participants described being disappointed with their church and clergy. In addition, many participants described a decrease in religious or spiritual practices at the time of the abuse, which were then restored on leaving the abusive relationship. That religious or spiritual faith can be an important means to cope with abusive relationships and can increase or decrease in the face of abuse or trauma further emphasizes the potential importance of a spiritual assessment and continued evaluation of the individual’s spiritual coping strategies. In cases of domestic violence, clinicians need to ask patients if they feel that their faith is helpful. However, even though religious and spiritual issues may be important factors in coping, clinicians are cautioned against generalizing or assuming that simply endorsing spiritual faith or practices is automatically protective in such circumstances.

Finally, spiritual and religious factors in men diagnosed with HIV and AIDS have also been examined. Kendall (1994) examined the concept of “wellness” in 29 homosexual men in varying stages of HIV disease, defining *wellness spirituality* as “making sense out of one’s life and living life connected to that which was most meaningful.” More specific themes included belonging to a community, sharing, and opportunities to bond with other gay men to bolster a sense of identity and combat feelings of rejection, as well as viewing HIV as an opportunity for spiritual growth and self-acceptance. However, HIV infection can exacerbate the sense of alienation from the church, and in Miller’s (2005) sample of interviewees, many left their churches as a result. Seegers (2007) noted that the gay men infected with HIV in her study all endorsed an active and valued spiritual life and religious practices and expressed their spirituality through practices at church, but none were openly gay or shared their HIV status with their clergy or church community.

In a study in the United Kingdom, Ridge et al. (2008) distinguished the experiences of religious and spiritual faith between gay white men and black African men and women infected with HIV. African individuals described continued religious participation and church worship as an important source of support and hope, despite the stigma against individuals with HIV, whether heterosexual or homosexual. However, white gay men in this study experienced their sexual orientation and HIV status as targets of religious intolerance, and although often rejecting religion, gay men still described themselves as spiritual, albeit struggling to reconcile having been raised to consider homosexuality as sinful. Thus, when evaluating patients who are homosexual, clinicians also need to ask about their religious and spiritual beliefs and how these affect their feelings about their sexuality and participation in their spiritual community.

Cultural Features of the Relationship Between the Individual and the Clinician

Cultural differences and similarities can have a significant influence on the relationship between the patient and the clinician, and this section encourages the clinician to consider these factors as part of the cultural formulation. In addition, the setting of the clinical encounter, such as an outpatient office or an intensive care unit hospital room, may also accentuate cultural differences and challenges. Even without obvious perceived differences in cultural back-

grounds or ethnicity, religious and spiritual differences between the patient and the therapist may play an important role in psychiatric care, regardless of whether psychiatrists and other mental health professionals believe it is appropriate or are confident in their ability to address the spiritual and religious lives of their patients. Awareness of the patient's religious or spiritual beliefs and practices allows the therapist to accommodate such beliefs in the case formulation of the patient, including the patient's struggle to find meaning, the patient's means of relating to others, the effect of spiritual beliefs on the transference relationship between the patient and the therapist, and the therapist's capacity to make appropriate referrals when religious or spiritual questions extend beyond the therapist's expertise (Lomax et al. 2002). Therefore, it is critical to assess the patient's religious beliefs during the initial session because the patient may have a preference for a therapist who belongs to the same faith.

Several studies suggest that many patients desire their physicians to be accepting of and attentive to their religious or spiritual beliefs. This is illustrated in Video 6–2, in which the patient directly asks the interviewer, “Are you Jewish?” She explains her concern of being understood: “I’m throwing out these terms, and I’m not sure if you know what they are.” With her previous therapist, she felt comfortable being understood because they shared the same faith: “My last therapist was Jewish, and... it seemed like she really understood stuff, because we had that in common.... She could understand what it feels like.... If you don’t have it, you can see what it looks like, but you don’t really know what it’s like.”



Video Illustration 6–2: Transference and countertransference (5:18)

One qualitative study that used moderated focus groups of patients who had experienced a life-threatening illness found that patients generally desired their physicians to inquire into coping and means of social support and wanted their physicians to be willing to participate in a spiritually oriented discussion when relevant (Hebert et al. 2001). A large survey of 456 patients found that two-thirds of the participants thought that physicians should be aware of their patients' religious and spiritual beliefs (MacLean et al. 2003). Patient preferences about three different spiritual interventions (asking about

beliefs, silent prayer, and prayer with the patient) varied depending on the medical seriousness and the medical setting. Only one-third expressed a preference for physicians to inquire about their religious beliefs during a routine office visit, but in the context of dying, preference for physician inquiry increased to 70%. Likewise, only a minority endorsed a preference for prayer with their physician during a routine office visit, but up to half of the participants endorsed a desire to pray with their physician if dying. One Canadian study compared the attitudes, expectations, and practices of psychiatrists with those of patients regarding incorporation of spiritual inquiry in mental health care. More than 50% of patients indicated that their spiritual or religious issues should be addressed in psychiatric treatment, and 24% endorsed that spiritual or religious faith played an important part in their selection of a psychiatrist (Baetz et al. 2004). Thus, patients want to know what clinicians believe and that the clinicians care about them by asking about their religion. The spiritual history in itself can be a tool to nurture rapport between the clinician and the patient.

Several studies have suggested a “religiosity gap” between psychiatrists, psychotherapists, and the general public, and this “gap” could contribute to clinician-patient misunderstandings and missed therapeutic opportunities when spiritual or religious topics are approached. A 1975 American Psychiatric Association poll reported that fewer than half of psychiatrists endorsed a belief in God, compared with more than 90% of Americans (American Psychiatric Association 1975). In comparison, a more recent survey of psychiatric residents in five residency training programs in the mid-1990s reported that more than 75% of the psychiatric residents endorsed a belief in God, and almost half endorsed that their religious beliefs affected their decision to enter medicine as a career (Waldfoegel et al. 1998). Meanwhile, the Canadian study comparing psychiatrists’ and patients’ religious attitudes and practices noted that Canadian psychiatrists endorsed significantly lower rates of religiousness than did Canadian patients or the general public as measured by reports of religious attendance and private spiritual or religious activity (Baetz et al. 2004).

The American Psychiatric Association’s (2006b) document “Religious/Spiritual Commitments and Psychiatric Practice” emphasizes that psychiatrists should inquire into and respect their patients’ worldviews and religious and spiritual beliefs and includes several examples of problems that may arise when psychiatrists are unaware of or violate treatment boundaries around re-

ligious and spiritual beliefs and practices. At the same time, clinicians should reflect on their own religious and spiritual development so that they can effectively understand and empathize with the individual's beliefs and practices as well as not inadvertently adversely affect the relationship. Thus, clinicians not only need to ask patients what their religious beliefs are but also must anticipate patients inquiring about their clinicians' religious views.

Overall Cultural Assessment and Interventions

The final component of the OCF summarizes the information about the patient's cultural identity, explanatory models and help-seeking behavior, psychosocial stressors and coping strategies, and effect on the clinician-patient relationship, with the goal of recognizing those cultural factors that contribute to the differential diagnosis and treatment planning and management. Lewis-Fernández and Díaz (2002) suggested that regular use of the OCF not only teaches providers how to use this information for these clinical responsibilities but also exposes clinicians over time to a wealth of information about cultural perspectives and knowledge. Assessing the degree to which religious and spiritual phenomena may be normative for the culture, a cultural concept of distress (formerly a culture-bound syndrome), a religious or spiritual problem, a sign or symptom of a mental disorder, or a mixture of these possibilities begins with the clinician's use of the OCF.

This process can be aided by consulting with the patient's family, friends, and pastoral counselors, chaplains, or clergy. Under such circumstances, pastoral counselors, chaplains, or clergy may be considered a "spiritual or religious broker" similar to the "cultural broker" described by Kirmayer et al. (2003). Although a religious or spiritual "match" between the clinician and the patient may minimize misunderstandings about religious beliefs, practices, and experiences, such a match also potentially risks ethical violations of role boundaries, displacing religious authority, and incorrectly assuming shared values (Richards and Bergin 2005).

A knowledge base of various cultures, religions, and spiritual beliefs and practices is helpful to the clinician (e.g., Josephson and Peteet 2004), but comprehensive information is not always essential to providing spiritually or religiously competent and sensitive care. Rather, a solid knowledge of the phenomenology of mental disorders, an ability to listen for and be aware of re-

ligious and spiritual themes, and comfort in performing a sensitive cultural and spiritual assessment may allow clinicians to incorporate religious or spiritually relevant information into the overall clinical assessment and treatment plan of the patient (Blass 2007; Miller and Thoresen 1999). Actively listening for religious or existential themes may identify the use of metaphors and narratives by the patient to describe spiritual experiences and ideas otherwise difficult to articulate (Griffith and Griffith 2001).

Conclusion

Despite the importance of religious and spiritual factors in the care of patients, few studies have been done on the role of spiritual assessment and clinical interventions in medical and mental health outcomes. Koenig (2007) noted that the act of performing a sensitive spiritual assessment may improve rapport and strengthen the provider-patient relationship, which in turn may improve adherence to medical recommendations, inspire hope, and identify potential community supports. Huguelet et al. (2011) found that the addition of a spiritual assessment was well accepted and tolerated by patients, and although it was not associated with a measure of medication adherence, it was associated with significantly higher attendance at follow-up appointments compared with a control group offered standard care without a spiritual assessment.

Worthington et al. (2011) performed a meta-analytic review examining the outcomes of religious or spiritual psychotherapies. They found that religious or spiritual psychotherapies resulted in greater improvement compared with no-treatment controls and that patients receiving religious or spiritual psychotherapies showed greater improvement in psychological and spiritual outcomes. When religious or spiritual psychotherapies and alternative psychotherapies using similar theoretical orientation and duration of treatment were compared, no differences were found between the two groups in psychological outcomes, although patients in the religious or spiritual psychotherapies group had better spiritual outcomes. As such, the inclusion of careful and sensitive spiritual assessments and the accommodation of patients' spiritual and religious values in treatment are well tolerated by patients and can be at least as effective as traditional psychotherapies.

A skilled clinician can weave questions about religion and spirituality into a patient's cultural beliefs about his or her illness, developmental history, and cultural identity, as well as discuss with the patient his or her level of comfort with the clinician's stated or presumed religious beliefs.

Routinely including religious and spiritual information provides insight into the patient's personal coping and social resources and allows the patient to express and explore religious, spiritual, and existential issues that may contribute to the patient's suffering. With practice, care, and respect, clinicians can become increasingly comfortable with obtaining spiritual histories, adding minimal time to the appointment and potentially contributing to the physician-patient relationship. Because of the prominent role of religion and spirituality in the values, attitudes, and beliefs of different cultures and ethnicities, this information can be organized with the OCF and Cultural Formulation Interview outlined in DSM-5.

References

- Accreditation Council for Graduate Medical Education: ACGME Program Requirements for Graduate Medical Education in Psychiatry. Chicago, IL, Accreditation Council for Graduate Medical Education, July 1, 2007. Available at: http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/400_psychiatry_07012007_u04122008.pdf. Accessed April 20, 2014.
- Ali OM, Milstein G, Marzuk PM: The imam's role in meeting the counseling needs of Muslim communities in the United States. *Psychiatr Serv* 56(2):202–205, 2005
- American Psychiatric Association: Psychiatrists' Viewpoints on Religion and Their Services to Religious Institutions and the Ministry (Task Force Report 10). Washington, DC, American Psychiatric Press, 1975
- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition. Washington, DC, American Psychiatric Association, 1994
- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000
- American Psychiatric Association: Practice Guidelines for the Psychiatric Evaluation of Adults, 2nd Edition. Washington, DC, American Psychiatric Association, 2006a. Available at: <http://www.psychiatryonline.com/content.aspx?aID=137162>. Accessed September 4, 2007.

- American Psychiatric Association: Religious/Spiritual Commitments and Psychiatric Practice: Resource Document. Washington, DC, American Psychiatric Association, 2006b. Available at: <http://www.psychiatry.org/learn/library--archives/resource-documents>. Accessed May 27, 2014.
- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Washington, DC, American Psychiatric Association, 2013
- Anandarajah G, Hight E: Spirituality and medical practice: using the HOPE questions as a practical tool for spiritual assessment. *Am Fam Physician* 63(1):81–89, 2001
- Baetz M, Larson DB, Marcoux G, et al: Canadian psychiatric inpatient religious commitment: an association with mental health. *Can J Psychiatry* 47(2):159–166, 2002
- Baetz M, Griffin R, Bowen R, et al: Spirituality and psychiatry in Canada: psychiatric practice compared with patient expectations. *Can J Psychiatry* 49(4):265–271, 2004
- Blass DM: A pragmatic approach to teaching psychiatry residents the assessment and treatment of religious patients. *Acad Psychiatry* 31(1):25–31, 2007
- Block SD: Perspectives on care at the close of life: psychological considerations, growth, and transcendence at the end of life: the art of the possible. *JAMA* 285(22):2898–2905, 2001
- Colucci E, Martin G: Religion and spirituality along the suicidal path. *Suicide Life Threat Behav* 38(2):229–244, 2008
- Cook JM, Pearson JL, Thompson R, et al: Suicidality in older African Americans: findings from the EPOCH study. *Am J Geriatr Psychiatry* 10(4):437–446, 2002
- Dervic K, Oquendo MA, Grunebaum MF, et al: Religious affiliation and suicide attempt. *Am J Psychiatry* 161(12):2303–2308, 2004
- Dervic K, Grunebaum MF, Burke AK, et al: Protective factors against suicidal behavior in depressed adults reporting childhood abuse. *J Nerv Ment Dis* 194(12):971–974, 2006
- Falsetti SA, Resick PA, Davis JL: Changes in religious beliefs following trauma. *J Trauma Stress* 16(4):391–398, 2003
- Fontana A, Rosenheck R: Trauma, change in strength of religious faith, and mental health service use among veterans treated for PTSD. *J Nerv Ment Dis* 192(9):579–584, 2004
- García DI, Gray-Stanley J, Ramirez-Valles J: “The priest obviously doesn’t know that I’m gay”: the religious and spiritual journeys of Latino gay men. *J Homosex* 55(3):411–436, 2008
- Gearing RE, Lizardi D: Religion and suicide. *J Relig Health* 48(3):332–341, 2009
- Griffith J, Griffith M: *Encountering the Sacred in Psychotherapy: How to Talk With People About Their Spiritual Lives*. New York, Guilford, 2001

- Hebert RS, Jenckes MW, Ford DE, et al: Patient perspectives on spirituality and the patient-physician relationship. *J Gen Intern Med* 16(10):685–692, 2001
- Huguelet P, Mohr S, Borras L, et al: Spirituality and religious practices among outpatients with schizophrenia and their clinicians. *Psychiatr Serv* 57(3):366–372, 2006
- Huguelet P, Mohr S, Betrisey C, et al: A randomized trial of spiritual assessment of outpatients with schizophrenia: patients' and clinicians' experience. *Psychiatr Serv* 62(1):79–86, 2011
- Josephson AM, Peteet JR (eds): *Handbook of Spirituality and Worldview in Clinical Practice*. Washington, DC, American Psychiatric Publishing, 2004
- Kendall J: Wellness spirituality in homosexual men with HIV infection. *J Assoc Nurses AIDS Care* 5(4):28–34, 1994
- Kirmayer LJ, Groleau D, Guzder J, et al: Cultural consultation: a model of mental health service for multicultural societies. *Can J Psychiatry* 48(3):145–153, 2003
- Koenig HG: *Spirituality in Patient Care: Why, How, When and What*, 2nd Edition. Philadelphia, PA, Templeton Foundation Press, 2007
- Koenig HG, Larson DB, Larson SS: Religion and coping with serious medical illness. *Ann Pharmacother* 35(3):352–359, 2001
- Lewis-Fernández R, Díaz N: The cultural formulation: a method for assessing cultural factors affecting the clinical encounter. *Psychiatr Q* 73(4):271–295, 2002
- Lizardi D, Dervic K, Grunebaum MF, et al: The role of moral objections to suicide in the assessment of suicidal patients. *J Psychiatr Res* 42(10):815–821, 2008
- Lo B, Ruston D, Kates LW, et al: Discussing religious and spiritual issues at the end of life: a practical guide for physicians. *JAMA* 287(6):749–754, 2002
- Lomax JW 2nd, Karff RS, McKenny GP: Ethical considerations in the integration of religion and psychotherapy: three perspectives. *Psychiatr Clin North Am* 25(3):547–559, 2002
- MacLean CD, Susi B, Phifer N, et al: Patient preference for physician discussion and practice of spirituality. *J Gen Intern Med* 18(1):38–43, 2003
- Maugans TA: The SPIRITual history. *Arch Fam Med* 5(1):11–16, 1996
- Miller RL Jr: An appointment with God: AIDS, place, and spirituality. *J Sex Res* 42(1):35–45, 2005
- Miller RL Jr: Legacy denied: African American gay men, AIDS, and the black church. *Soc Work* 52(1):51–61, 2007
- Miller WR, Thoresen CE: Spirituality and health, in *Integrating Spirituality Into Treatment*. Edited by Miller WR. Washington DC, American Psychological Association, 1999, pp 3–18

- Mohr S, Brandt P-Y, Borrás L, et al: Toward an integration of spirituality and religiousness into the psychosocial dimension of schizophrenia. *Am J Psychiatry* 163(11):1952–1959, 2006
- Neeleman J, Lewis G: Religious identity and comfort beliefs in three groups of psychiatric patients and a group of medical controls. *Int J Soc Psychiatry* 40:2124–2134, 1994
- Pargament KI, Brant CR: Religion and coping, in *Handbook of Religion and Mental Health*. Edited by Koenig HG. San Diego, CA, Academic Press, 1998, pp 111–128
- Pargament KI, Koenig HG, Perez LM: The many methods of religious coping: development and initial validation of the RCOPE. *J Clin Psychol* 56(4):519–543, 2000
- Pargament KI, Koenig HG, Tarakeshwar N, et al: Religious struggle as a predictor of mortality among medically ill elderly patients: a 2-year longitudinal study. *Arch Intern Med* 161(15):1881–1885, 2001
- Pargament KI, Koenig HG, Tarakeshwar N, et al: Religious coping methods as predictors of psychological, physical and spiritual outcomes among medically ill elderly patients: a two-year longitudinal study. *J Health Psychol* 9(6):713–730, 2004
- Peteet JR: Therapeutic implications of worldview, in *Handbook of Spirituality and Worldview in Clinical Practice*. Edited by Josephson AM, Peteet JR. Washington, DC, American Psychiatric Publishing, 2004, pp 47–59
- Potter H: Battered black women's use of religious services and spirituality for assistance in leaving abusive relationships. *Violence Against Women* 13(3):262–284, 2007
- Pulchalski C: Spiritual assessment in clinical practice. *Psychiatr Ann* 36:150–155, 2006
- Rasic DT, Belik SL, Elias B, et al; Swampy Cree Suicide Prevention Team: spirituality, religion and suicidal behavior in a nationally representative sample. *J Affect Disord* 114(1–3):32–40, 2009
- Richards PS, Bergin AE: *A Spiritual Strategy for Counseling and Psychotherapy*, 2nd Edition. Washington, DC, American Psychological Association, 2005
- Ridge D, Williams I, Anderson J, et al: Like a prayer: the role of spirituality and religion for people living with HIV in the UK. *Sociol Health Illn* 30(3):413–428, 2008
- Seegers DL: Spiritual and religious experiences of gay men with HIV illness. *J Assoc Nurses AIDS Care* 18(3):5–12, 2007
- Shafranske EP: Religion and mental health in early life, in *Religion and Mental Health*. Edited by Schumaker JF. New York, Oxford University Press, 1992, pp 163–176
- Stotland NL: Tug-of-war: domestic abuse and the misuse of religion. *Am J Psychiatry* 157(5):696–702, 2000

- Tan PP: The importance of spirituality among gay and lesbian individuals. *J Homosex* 49(2):135–144, 2005
- Waldfoegel S, Wolpe PR, Shmuely Y: Religious training and religiosity in psychiatry residency programs. *Acad Psychiatry* 22:29–35, 1998
- Watlington CG, Murphy CM: The roles of religion and spirituality among African American survivors of domestic violence. *J Clin Psychol* 62(7):837–857, 2006
- Weaver AJ: Mental health professionals working with religious leaders, in *Handbook of Religion and Mental Health*. Edited by Koenig HG. San Diego, CA, Academic Press, 1998, pp 349–364
- Worthington EL, Hook JN, Davis DE, et al: Religion and spirituality. *J Clin Psychol* 67:204–214, 2011
- Young JL, Griffith EEH, Williams DR: The integral role of pastoral counseling by African-American clergy in community mental health. *Psychiatr Serv* 54(5):688–692, 2003

Ethnopsychopharmacology

David C. Henderson, M.D.

Brenda Vincenzi, M.D.

Ethnic variation in response to a large array of psychotropic medications has been reported over the past 30 years (Kalow 1992). Early research findings from studies in the field of pharmacogenetics indicate that ethnic-specific polymorphic variability may be in large part responsible for these differences (Lin et al. 1993). These ethnic-specific mutations correspond to varying efficiencies in drug metabolism among members of different ethnic populations. The biotransformation systems that break down pharmacological agents also

Dr. Henderson would like to acknowledge the contribution of Dr. Michael W. Smith of the Research Center on the Psychobiology of Ethnicity and the Department of Psychiatry, UCLA School of Medicine, Harbor-UCLA Medical Center, who passed away in 2005, shortly before the publication of the first edition of this book. Without his invaluable input into this chapter, it would not be as complete as it is today. Supported in part by the Research Center on the Psychobiology of Ethnicity MH47193.

show environmental responsiveness, such as inhibition or induction of enzyme activity due to dietary substances. Nonbiological factors such as age, gender, diet, and smoking (Figure 11–1) also play a role in determining differential response. Additionally, misdiagnosis due to ethnic variation in symptomatology may lead to the use of treatment that is ineffectual, inappropriate, or possibly toxic (Lawson 1996). In this chapter we briefly review clinical reports of ethnic variation with several different classes of psychotropics and closely examine the relationship of pharmacogenetics, ethnicity, and environmental factors.

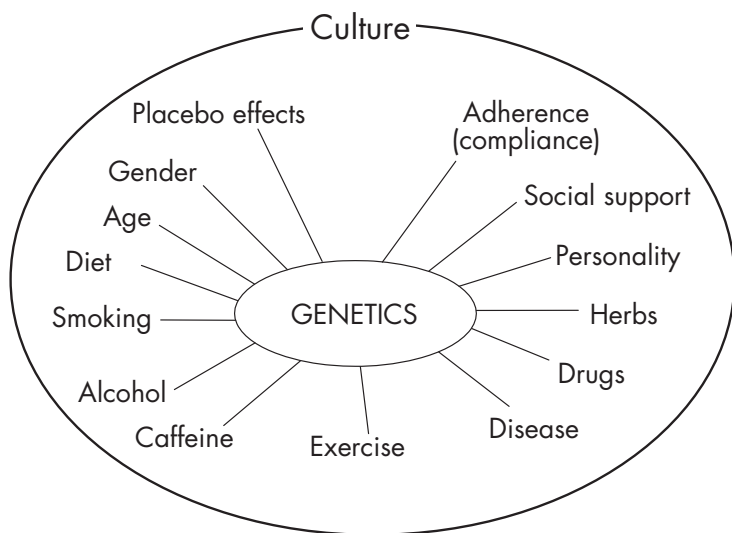


Figure 11–1. Factors affecting drug metabolism.

Introduction to the Pharmacogenetics of Drug-Metabolizing Enzymes

Several different xenobiotic-metabolizing enzymes have been identified in humans (Kalow 1992). Among these, the cytochrome P450 (CYP450) drug-metabolizing enzymes appear to be the most clinically relevant for the practice of psychiatry. They have also been the major focus of pharmacogenetic research (Gonzalez and Nebert 1990). The human CYP450 genes belong to a well-conserved gene family existing in all biological systems, including bacteria and plants. They perform vital functions (e.g., biosynthesis) in addition to the biotransformation of xenobiotics (foreign substances). More than 20 human CYP450 enzymes have been identified and cloned. Of these, the following seven may be regarded as most important in terms of the metabolism of psychotropic medications: CYP2D6, CYP3A4, CYP1A2, CYP2C19, CYP2C9, CYP2E1, and CYP2A6. The first four have the most relevance to psychiatry and are discussed in greater detail later in this chapter. It is believed that the differences observed in ethnic minorities who take psychotropics, such as the variations seen in efficacy, side effects, and plasma levels, are due to varying gene expression, and thus the amount of a particular enzyme present, among other factors.

Ethnic Variation in Medication Response

Research on the variation in different ethnic groups' response to psychiatric medications has been limited to several classes of medication, including antidepressants, antipsychotics, and benzodiazepines, which are discussed in the following sections.

Antidepressants

Because of a variety of factors including structural, linguistic, and cultural barriers to mental health care, depressed patients with ethnic minority backgrounds are infrequently seen by mental health professionals (Lin and Cheung 1999). When they do reach the system, many are misdiagnosed (Adebimpe 1984) and are not likely to receive treatment with antidepressants. Correspondingly, these facts verify that ethnic minority patients have rarely been in-

cluded in most controlled clinical trials or other types of clinical studies on depression (Lawson 1996), thus limiting the amount of data available to guide the use of these medications in ethnic minority populations.

The paucity of objective data in regard to the use of antidepressants for ethnic minority patients is troublesome, particularly because ethnic differences in the therapeutic range and side effect profiles of tricyclic antidepressants (TCAs) have been repeatedly reported (Silver et al. 1993). Among depressed patients, African Americans were less likely to receive antidepressants in comparison with whites, and those who did receive them also were significantly more likely to be given older antidepressants (e.g., tricyclics) rather than the newer, more developed antidepressants (e.g., selective serotonin reuptake inhibitors [SSRIs]) (Melfi et al. 2000). In studies with TCAs, African Americans had a faster and more favorable clinical response (Silver et al. 1993), as well as increased serious side effects, such as delirium (Livingston et al. 1983). Reports of elevated TCA levels in African Americans in several studies suggest that pharmacogenetic factors may be responsible for the differential treatment response and the higher rate of TCA side effects (Silver et al. 1993).

Studies involving Asians reported a substantially lower dose requirement of antidepressants for the treatment of depression (Silver et al. 1993). This may be due in part to the slower metabolism of TCAs reported in Asian subjects in several studies (Lin et al. 1993).

In a retrospective study of depressed Hispanic (predominantly Puerto Rican) female outpatients in New York, Hispanics responded to half the dosage given to non-Hispanic white patients and experienced more side effects (78% vs. 33%) and had higher study dropout rates due to side effects (17% vs. 4.8%) (Marcos and Cancro 1982). In a prospective study of antidepressant response in patients from Colombia and the United States, the efficacy of trazodone was compared with that of imipramine and placebo in patients with depression (Escobar and Tuason 1980). The Colombian patients showed more improvement, regardless of the treatment selected, as well as significantly more anticholinergic side effects. No statistically significant differences between Hispanics (Mexican Americans) and non-Hispanic whites in pharmacokinetic studies of imipramine and nortriptyline have been reported (Gaviria et al. 1986). The results of these studies are consistent with reports of CYP2D6 metabolism in Mexican Americans (Mendoza et al. 2001).

Much less is known about ethnic variation with the newer antidepressant agents such as the SSRIs. For example, few reports have compared treatment response to SSRIs between African American and white depressed patients. In a small study of HIV-positive depressed patients, African Americans were more likely to be nonresponders to fluoxetine treatment than were whites (Wagner et al. 1998). In contrast, a small study of paroxetine in treating elderly African American and white patients with a DSM-IV diagnosis of major depression (Lesser et al. 1996) reported comparable response to medication and side effect rates in both groups.

Another study reported no significant difference between African American and white depressed participants and their response to and tolerability of duloxetine (Bailey et al. 2006). In a small open-label 6-week study of fluoxetine or paroxetine (20 mg/day) in the treatment of depression in Hispanic (Mexican descent) and white females (Alonso et al. 1997), similar improvement was noted, but the white group reported significantly more side effects.

Antipsychotics

Ethnic variations in response include reports of higher blood levels of haloperidol (up to 50%) in Asian volunteers without schizophrenia (Lin et al. 1993) (Figure 11–2) and patients with schizophrenia (Potkin et al. 1984) compared with their white counterparts. A series of studies (Jann et al. 1993) indicated that Asians have a lower rate of metabolism and consequently more prominent effects when given equivalent doses of medication. Greater prolactin responses to haloperidol in Asians have also been reported (Lin et al. 1989). In a multiethnic study of patients taking therapeutic doses of haloperidol, a significantly different pharmacokinetic profile was noted in Chinese and African Americans compared with whites and Hispanics (Jann et al. 1993). Asian patients with schizophrenia participating in a clinical treatment study responded optimally to a significantly lower plasma haloperidol concentration (Lin et al. 1989) than did their white counterparts, suggesting that pharmacodynamic factors also contribute to ethnic differences in response to haloperidol.

In a study conducted in San Francisco, California, no ethnic variation in antipsychotic dosage or side effects was noted. However, immigrant Asian and Hispanic patients received significantly lower dosages than did U.S.-born

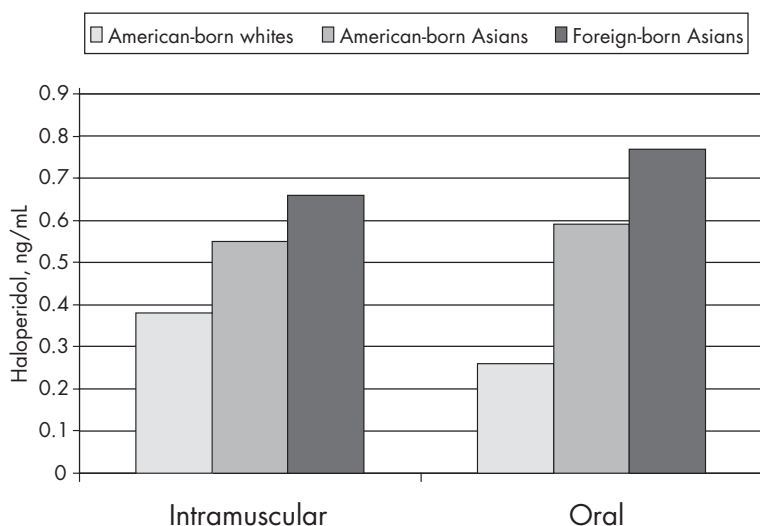


Figure 11–2. Haloperidol metabolism by route and ethnicity.

Source. Lin et al. 1988.

Asian and Hispanic patients (Lu et al. 1987). In a similar study conducted in New York with Anglo, Asian, and Hispanic (Puerto Rican and Dominican) patients, the Hispanic and Asian patients received lower doses and lower-potency antipsychotics (Collazo et al. 1996). As in the previous study (Lu et al. 1987), the Hispanic and Asian subset (24 of 27 Hispanics and all the Asian patients) were foreign born. Environmental and cultural influences such as diet, alcohol, smoking, and exposure to toxins may explain the observed differences in drug response in these studies.

Although limited information is available about the treatment and subsequent response to the newer-generation atypical antipsychotic agents among different ethnic groups, the existing data do suggest that there are ethnic variations in prescription rates (Kuno and Rothbard 2002) and in response to these new agents (Frackiewicz et al. 1999; Matsuda et al. 1996). Earlier reported gaps between ethnic groups in the number of prescriptions of atypical

agents have decreased over the past decade but continue to be apparent for African Americans (Daumit et al. 2003).

Clozapine, the first atypical agent used in the United States, has shown variations by ethnicity in dosage, response, and side effects (Matsuda et al. 1996). Lower dosage requirements compared with white patients have been reported in Chinese patients (Chong et al. 2000), Korean American patients (Matsuda et al. 1996), and patients from Argentina and Chile (Ramirez 1996). In one study, a dosage requirement of 169 mg/day in Asian patients and 408 mg/day in white patients was reported (Chong et al. 2000). Lower blood levels in Korean Americans were associated with better response and more side effects than in white patients (Matsuda et al. 1996). The reports of higher plasma concentrations of clozapine in Chinese patients suggest that ethnic variations in metabolism may be responsible for these dosage variations (Chong et al. 2000). Asian patients also appear to be at greater risk for developing the more serious side effect of agranulocytosis. Asian patients prescribed clozapine in the United Kingdom were found to have almost 2.5 times the risk of developing agranulocytosis. Mandatory blood monitoring has proved essential in prevention of agranulocytosis. However, these guidelines may also have prevented certain ethnic groups such as African American and Afro-Caribbean patients in the United Kingdom from receiving or continuing with clozapine because of a significantly lower baseline white blood cell count than in non-African American patients (Juarez-Reyes et al. 1996). This benign neutropenia often makes clinicians hesitant to prescribe clozapine to these populations or results in early and inappropriate discontinuation (Kelly et al. 2007; Whiskey et al. 2011). In fact, in the United Kingdom, different guidelines for clozapine monitoring are used for Afro-Caribbean patients, with lower white blood cell count and absolute neutrophil count reference values, enabling wider use in these populations (Chaudhry et al. 2008).

Risperidone and olanzapine have shown variations by ethnicity in metabolism, dosage requirements, and response. Asians were reported to have 30% higher plasma concentrations compared with whites (Lane et al. 1999b). A bimodal distribution of dosage requirements for risperidone has been reported in Hispanics in Latin America, with one group requiring dosages up to 6 mg/day and another responding well to lower dosages (Ramirez 1996). In a double-blind, parallel-group, inpatient multicenter study of patients treated with risperidone conducted in the United States, Hispanic (Puerto Rican and

Dominican) patients had a more rapid rate of symptom improvement and a higher rate of adverse effects, including extrapyramidal symptoms (EPS), than did non-Hispanic patients (Frackiewicz et al. 1999). Initial reviews of pharmacokinetic studies conducted with African American (Lawson 1996) and Chinese (Lane et al. 1999a) patients identified no important differences in the disposition of olanzapine compared with white subjects. A more recent study, however, found lower dosage requirements in Japanese patients (9.4 ± 3.6 mg/day) (Ishigooka et al. 2001) compared with white patients (12.4 mg/day) (Conley and Mahmoud 2001) (Table 11–1). The potential for both clozapine and olanzapine to cause weight gain may be especially detrimental in ethnic minorities who have an increased risk of gaining weight and developing diabetes (Jin et al. 2002). In a review of published case reports, African Americans accounted for almost half of all cases of new-onset diabetes with atypical agents (Jin et al. 2002).

Benzodiazepines

Significant differences in the prescription rates, dosing, and side effects of benzodiazepines between Asians and whites have been reported both clinically (Lin et al. 1993) and in several pharmacokinetic studies (Ghoneim et al. 1981; Lin et al. 1989). Slower metabolism and higher plasma concentrations were noted for both diazepam (Ghoneim et al. 1981) and alprazolam (Lin et al. 1988).

African Americans were found to have notably increased clearance of adinazolam, resulting in significantly higher concentrations of *N*-desmethyladinazolam (a metabolite of adinazolam), higher sedation, and greater reduction in psychomotor performance scores than in whites. Adinazolam is almost exclusively eliminated by hepatic oxidation to *N*-desmethyladinazolam, so these findings suggested that African Americans may have a higher metabolic capacity for adinazolam (Ajir et al. 1997; Fleishaker et al. 1992; Lin et al. 1993).

Pharmacogenetics of Drug-Metabolizing Enzymes

The four CYP450 enzymes that are most important in terms of the metabolism of psychotropic medications are CYP2D6, CYP3A4, CYP1A2, and CYP2C19 (Table 11–2). Although the CYP450 enzymes are found in large

Table 11–1. Ethnicity and atypical antipsychotics

Ethnicity	Clozapine	Risperidone	Olanzapine
African Americans	Benign neutropenia prevents selection for clozapine Low white blood cell count may result in discontinuation, increased diabetes mellitus, and death from cardiovascular disease risk ^a	NA	No variation in dosage or side effects noted ^b Increased rate of diabetic DKA with olanzapine and clozapine in case reports; 48% of cases were African American ^c
Asians	Often excluded by selection criteria Lower dosage results in higher plasma levels (30%–50%) in Chinese Lower dosage causes increased side effects in Koreans Lower dosage, 169 mg/day vs. 408 mg/day, prescribed for Southeast Asians Higher risk of agranulocytosis (2.4×)	32% higher plasma concentration compared with whites In Singapore, at average dosage of 5.6 mg, 85% of treatment-resistant patients responded and showed improvement in EPS from baseline	Increased plasma concentration in Japanese Lower dosage, 11.3 mg vs. 17.1 mg, in Asians (LA County DMH)
Hispanics	Argentina and Chile: lower dosages increased diabetes mellitus and death from cardiovascular disease ^a	Faster response in Puerto Rican and Dominican patients	NA

Note. DKA=diabetic ketoacidosis; DMH=Department of Mental Health; EPS=extrapyramidal side effects; NA=not available.

Source. ^aHenderson et al. 2005; ^bLawson 1996; ^cJin et al. 2002.

Table 11–2. Summary: major human cytochrome P450 (CYP450) enzymes and their psychotropic substrates

CYP2D6	<p>Antidepressants: amitriptyline, clomipramine, imipramine, desipramine, nortriptyline, trimipramine, fluoxetine, paroxetine, venlafaxine, trazodone, duloxetine, mirtazapine</p> <p>Antipsychotics: aripiprazole, chlorpromazine, thioridazine, perphenazine, fluphenazine, haloperidol, risperidone, clozapine, olanzapine, sertindole</p> <p>Others: codeine, oxycodone, propranolol, timolol, dextromethorphan, donepezil, flecainide, galantamine</p>
CYP3A4	<p>Antidepressants: mirtazapine, nefazodone, sertraline, citalopram, trazodone</p> <p>Antipsychotics: aripiprazole, clozapine, haloperidol, quetiapine, risperidone, sertindole, thioridazine, ziprasidone</p> <p>Mood stabilizers: carbamazepine, lamotrigine</p> <p>Calcium channel blockers/cardiovascular agents: amiodarone, amlodipine, atorvastatin, cerivastatin, diltiazem, felodipine, lercanidipine, lidocaine, lovastatin, nifedipine, nisoldipine, nitrendipine, nimodipine, quinidine, quinine, simvastatin, verapamil</p> <p>Antibiotics/antifungals/immune modulators/chemotherapy: clarithromycin, cyclosporine, erythromycin, dapsone, indinavir, ketoconazole, nelfinavir, saquinavir, ritonavir, paclitaxel, tamoxifen, vincristine, alfentanil, astemizole, chlorpheniramine, cisapride, cocaine, codeine, estrogens, fentanyl, hydrocortisone, methadone, progesterone, salmeterol, terfenadine, testosterone</p> <p>Others: acetaminophen, alprazolam, buspirone, clonazepam, midazolam, cocaine, codeine, dapsone, sildenafil</p>
CYP1A2	<p>Antidepressants: amitriptyline, clomipramine, L-deprenyl, doxepin, fluvoxamine, imipramine, mianserin, mirtazapine, nortriptyline</p>

Table 11–2. Summary: major human cytochrome P450 (CYP450) enzymes and their psychotropic substrates (*continued*)

	<p>Antipsychotics: clozapine, fluphenazine, haloperidol, thiothixene, olanzapine, perazine, perphenazine, pimozide, zotepine</p> <p>Others: caffeine, methadone, naproxen, propranolol, tacrine, theophylline, warfarin</p>
CYP2C19	<p>Antidepressants: imipramine, amitriptyline, clomipramine, citalopram, L-deprenyl (selegiline), moclobemide, sertraline, venlafaxine</p> <p>Antipsychotics: clozapine, perphenazine, zotepine</p> <p>Benzodiazepines: adinazolam, diazepam, flunitrazepam, temazepam, zolpidem</p> <p>Others: hexobarbital, omeprazole, nelfinavir, warfarin, zolpidem</p>

quantities primarily in the liver and the gut, they have also been found in other tissues, including the brain, whose polymorphic expression has been shown to be associated with personality traits, parkinsonism, and the risks of tardive dyskinesia, as well as substance abuse. For reasons that are still not completely understood (but at least partially related to the ability of some of these enzymes to convert procarcinogens to carcinogens), some of these CYP450 enzymes (especially CYP1A2, CYP2E1, and CYP2D6) are implicated in increased risk for various kinds of malignancies and autoimmune conditions such as systemic lupus erythematosus.

CYP2D6

CYP2D6 represents one of the most important CYP450 enzymes in psychiatry for at least three reasons.

1. It is the major metabolic pathway for many psychotropics (Table 11–3), including most heterocyclic antidepressants (especially the secondary amine tricyclics, such as desipramine and nortriptyline), some of the SSRIs

Table 11–3. Cytochrome P450 (CYP450) isoenzymes, inhibitors, and inducers

CYP1A2		CYP2C19	CYP2D6		CYP3A3/4	
Inhibitors						
Antidepressants		Fluoxetine	Fluoxetine	Norfluoxetine	Fluoxetine	Nefazodone
		Fluvoxamine	Bupropion	Sertraline	Fluvoxamine	Sertraline
		Imipramine	Fluvoxamine	Paroxetine		
			Moclobemide			
Antipsychotics			Clozapine	Perphenazine		
			Fluphenazine	Pimozide		
			Haloperidol	Thioridazine		
Other	Cimetidine	Cimetidine	Amiodarone	Hydroxyzine	Amiodarone	Itraconazole
	Ciprofloxacin/ norfloxacin	Diazepam	Astemizole	Loratadine	Cimetidine	Ketoconazole
	Fluoroquinolones	Felbamate	Celecoxib	Methadone	Clarithromycin	Mibefradil
	Fluvoxamine	Moclobemide	Chlorpheniramine	Moclobemide	Dexamethasone	Naringenin (grapefruit)
	Moclobemide	Omeprazole	Cimetidine	Promethazine	Diltiazem	Ritonavir

Table 11–3. Cytochrome P450 (CYP450) isoenzymes, inhibitors, and inducers (*continued*)

	CYP1A2	CYP2C19	CYP2D6		CYP3A3/4	
Other (continued)	Naringenin (grapefruit)	Phenytoin	Clemastine	Quinidine	Erythromycin	Troleandomycin
	Ticlopidine	Topiramate	Diphenhydramine	Ritonavir	Fluconazole	Verapamil
		Tranylcypromine	Hydroxybupropion	Terfenadine	Gestodene	Indinavir
Inducers						
	Omeprazole	Rifampin			Barbiturates	Phenytoin
	Tobacco				Carbamazepine	Rifampin
					Dexamethasone	Troglitazone
					Phenobarbital	

- (e.g., paroxetine and fluoxetine), and many commonly used antipsychotics, morphine derivatives, and cardiac drugs (Lin et al. 1993; Meyer 1994).
2. It is often responsible for drug-drug interactions because it is a low-capacity enzyme with high affinity (and thus is more easily saturated, leading to competitive inhibition).
 3. It is highly polymorphic, with more than 30 functional mutations (Pollock et al. 1991). Although most of these mutations are rare, seven of them are common but are variably distributed in different populations (as described below), and together these seven mutations capture more than 99% of the genetic variation (Gaedigk et al. 1999).

Because of the effects of these mutations, which range from inactivation to multiplication, individuals in any population can be classified into the following four groups: 1) poor metabolizers (PMs), who have no CYP2D6 enzyme activity; 2) intermediate metabolizers (IMs), who have slower activity because they possess alleles that encode less active forms of the enzyme; 3) extensive metabolizers (EMs), whose genes are not affected by functional mutations ("wild type" allele); and 4) ultrarapid metabolizers (UMs), who possess duplication or multiplication (up to 13 copies) of the gene (Lundqvist et al. 1999) (Table 11–4). Studies involving desipramine, venlafaxine, and several neuroleptics clearly suggest that CYP2D6 polymorphism is a major determinant of pharmacokinetics of CYP2D6 substrates as well as of clinical response (Lesard et al. 1999). The gene-dose effects have also been clearly established (Meyer et al. 1996).

Table 11–4. Cytochrome P450 (CYP450) 2D6 metabolic rates

Metabolic type	Metabolic rate	Plasma drug level	Clinical effects
Poor	None	Toxic	Side effects
Intermediate	Slow	High	Side effects at higher doses
Extensive	Normal	Normal	Normal response
Ultrarapid	Superfast	Low or none	No response at normal doses

As noted earlier, CYP2D6 is extremely polymorphic, and many of the identified mutations appear to be ethnic specific. For example, the mutation responsible for the high rate of PM patients among whites (5%–9%), *CYP2D6*4* (expressed as CYP2D6B), is rarely found in any other ethnic group. Similarly, alleles associated with lower enzyme activity and slower metabolism among those of African (*CYP2D6*17*) (Leathart et al. 1998; Masimirembwa and Hasler 1997) and Asian (*CYP2D6*10*) (Dahl et al. 1995) origins are rarely encountered in whites. These latter two alleles may be partially responsible for previous findings of lower therapeutic dose ranges observed in Asians with antidepressants and antipsychotics and in African Americans with TCAs (Lin et al. 1993). In contrast, Mexican Americans have significantly faster overall CYP2D6 activity because of very low rates of any of these impairing mutations (Mendoza et al. 2001) (Figure 11–3).

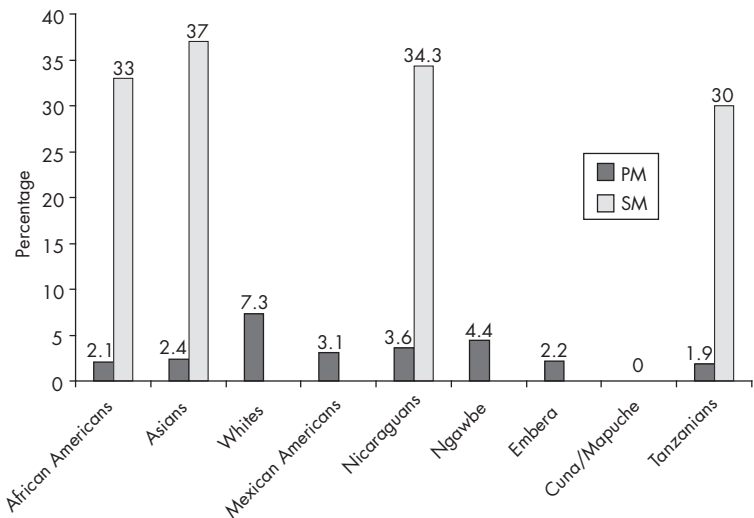


Figure 11–3. Cytochrome P450 (CYP450) 2D6 poor metabolizers (PM) and slow metabolizers (SM).

Source. Dahl et al. 1995; Leathart et al. 1998; Masimirembwa and Hasler 1997; Mendoza et al. 2001.

Ethnic variations have also been reported in UM individuals with duplicated genes. Lower rates are noted in Swedes (1%), American whites (3.5%), and Spaniards (7%; Agúndez et al. 1995), whereas higher rates are found in Arabs (19%; McLellan et al. 1997) and Ethiopians (29%; Aklillu et al. 1996) (Figure 11–4). Because of their extremely fast metabolism, UM patients are unlikely to respond to usual doses of medications that are biotransformed by CYP2D6 because they typically fail to achieve therapeutic levels. There have been reports of UM patients being regarded as noncompliant because they showed no evidence of drug effects while being given seemingly adequate doses of medications (Aklillu et al. 1996; Meyer 1994). Clinicians should routinely inquire about adherence to medication and confirm by checking plasma levels if available, keeping in mind that absence of measurable blood levels may be explained by either noncompliance or ultrafast metabolism. In contrast, the report of excessive side effects at low doses may be indicative of toxic drug levels resulting from an inherited impairment in drug metabolism or a drug interaction with a CYP2D6 inhibitor (e.g., fluoxetine, paroxetine).

CYP3A4

CYP3A4 is another important drug-metabolizing enzyme that is involved in the biotransformation of a large number of psychotropics, including most of the diazolo-benzodiazepines (e.g., alprazolam and clonazepam) and several newer antidepressants (e.g., nefazodone, mirtazapine, sertraline, and reboxetine) and neuroleptics (e.g., aripiprazole, clozapine, quetiapine, and ziprasidone) (Tables 11–2 and 11–3). It is the most abundant CYP450 enzyme expressed in the liver and is involved in the metabolism of many classes of drugs, including anticonvulsants, antihistamines (e.g., terfenadine), calcium channel blockers, macrolide antibiotics (e.g., erythromycin), steroid hormones, antiretrovirals, anticancer agents (e.g., ritonavir and cyclosporine), and antifungals (e.g., ketoconazole). CYP3A4 is often inhibited by its substrates, but drugs such as carbamazepine, phenobarbital, and rifampin can also induce it. Some diet-drug and herb-drug interactions, such as the inhibitory effects of grapefruit juice and the inductive effects of St. John's wort on the metabolism of substrates of CYP3A4, have also been reported (Piscitelli et al. 2000).

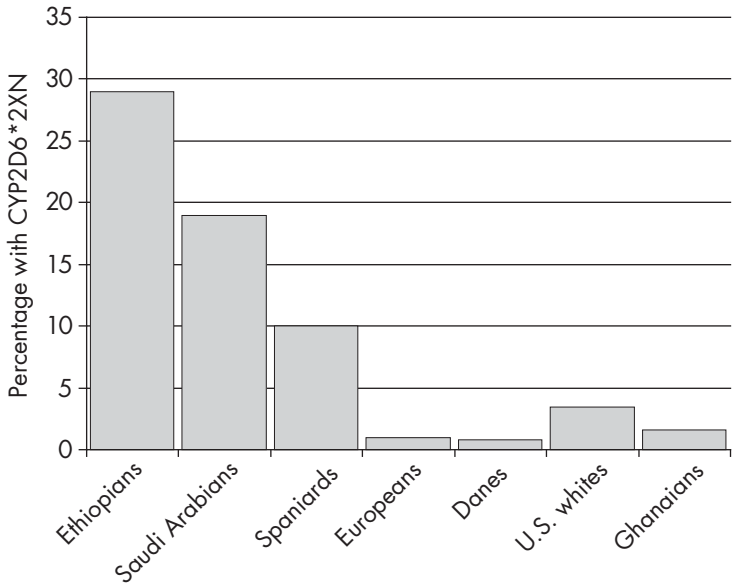


Figure 11–4. Cytochrome P450 (CYP450) 2D6 ultrarapid metabolizers.
Source. Agúndez et al. 1995; Akillu et al. 1996; McLellan et al. 1997.

Substantial interindividual and cross-ethnic variations of CYP3A4 have been amply documented. Asian Indians (Kinirons et al. 1996), East Asians (Lin et al. 1988), and Mexicans (Palma-Aguirre et al. 1994) have been shown to have lower CYP3A4 activity, whereas African Americans (Johnson 2000) and Africans (Sowunmi et al. 1995) appear to possess higher CYP3A4 activity when compared with whites. Until recently, no genetic polymorphism was identified, and the cause of these variations remained unknown. However, several polymorphisms have been reported. They all presented significant cross-ethnic variations. These include the **1B* (66.7% in African Americans, 4.2% in whites, and 0% in Chinese); **2* (thus far found only in whites, at a low rate of 0.7%); and **3*, **4*, **5*, and **6* (identified in Chinese) (Hsieh et al. 2001). In addition, a silent mutation (*C682T*) has been found in 4.7% of African Americans but not in other populations. Because these estimates were

derived from limited sample sizes, the exact distribution of these alleles remains to be determined. It is still not yet clear if these silent mutations can explain some of the cross-ethnic variations in the activity of CYP3A4 reported earlier. The polymorphism of the 5' promoter region of CYP3A4 was not found in persons of Japanese ethnicity (Naoe et al. 2000). CYP3A43 (rs472660) was found to predict olanzapine clearance in the National Institute of Mental Health Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) ($P = 5.9e^{-7}$). At standard antipsychotic doses, 50% of individuals with the high-clearance genotype (AA) had trough blood levels below the therapeutic range. A much higher proportion of African Americans carry the A allele compared with whites (allele frequency = 67% vs. 14%) (Bigos et al. 2011).

Although the clinical importance of genetic variation has yet to be determined, clinicians should be aware of the important role that environmental influences play in determining response (e.g., grapefruit juice may increase drug effects, whereas St. John's wort may decrease drug effects).

CYP1A2

CYP1A2 is involved in the metabolism of many medications, including most of the commonly used psychotropics, such as fluvoxamine, haloperidol, olanzapine, and clozapine. CYP1A2 is also responsible for the metabolism of important drugs and addictive substances, such as tacrine and caffeine (Carrillo and Benitez 2000) (Tables 11–2 and 11–3). CYP1A2 has striking interindividual variability in the rate of the metabolism of substrates, which may be due to the inhibition and induction of these enzymes by an array of non-genetically determined factors (Carrillo and Benitez 2000).

CYP1A2 is also highly inducible. Its inducers include indoles contained in cruciferous vegetables (e.g., broccoli, brussels sprouts, and cabbage), heterocyclic amines produced by charbroiling meat, constituents of tobacco, and high-protein diets (Ioannides 1999). Cigarette smoking has long been known to lower the steady-state concentrations of most psychotropics by up to 50% because of its ability to induce CYP1A2 (Schein 1995). Because this enzyme is highly inducible, it is reasonable to anticipate and predict that its catalytic activity varies substantially across ethnic/cultural demographic subgroups in association with cultural and socioeconomic divergent dietary habits (Smith

and Mendoza 1996). A specific polymorphism in intron 1 of the CYP1A2 gene (*C734A*) that markedly modulates the inducing productivity of the enzyme has been identified in whites (32% *C* allele frequency) (Sachse et al. 1999). Because no data are yet available for other ethnic groups in regard to the prevalence of this allele, it is unclear if ethnic variations in the polymorphism of this gene might explain ethnic differences in CYP1A2 activity (Masimirembwa and Hasler 1997; Masimirembwa et al. 1995; Relling et al. 1992).

Clinicians must be aware that concurrent smoking and use of CYP1A2 substrates (clozapine, haloperidol, and olanzapine) may result in decreased effectiveness of these medications compared with that seen in nonsmoking or lower-smoking environments (such as inpatient environments or among nonsmokers). Similarly, abrupt changes in CYP1A2-inducing factors (smoking cessation or changing from a high-protein to a low-protein diet) may result in an increase in side effects (because of increases in drug levels resulting from decreased drug metabolism). Appropriate dose adjustment will be needed to ensure effectiveness and avoid unnecessary side effects.

CYP2C19

Although the role of CYP2C19 in psychotropic metabolism does not appear as extensive as the ones discussed earlier, it does significantly influence the biotransformation of some of the commonly used medications, including diazepam, tertiary tricyclics, proguanil (agent used for the treatment of malaria), and omeprazole. Most recently, CYP2C19 has also been found to be partly responsible for the metabolism of three SSRI antidepressants: citalopram, escitalopram (Kobayashi et al. 1997), and sertraline (Wang et al. 2001). CYP2C19 also represents a dramatic example of the existence of both cross-ethnic and interindividual variations in drug metabolism. With *S*-mephenytoin used as the probe, studies have found that 13%–23% of East Asians (Chinese, Japanese, and Koreans) (Blaisdell et al. 2002) are PMs, as opposed to only 3%–5% of whites. Although a small study in Pittsburgh, Pennsylvania, indicated a high rate of PM patients (19%) among older African American depressed patients (Pollock et al. 1991), another study (Goldstein et al. 1997) reported PM rates similar to those of whites.

Identification and sequencing of the gene for the enzyme indicate that enzyme deficiency (the PM category) is caused by two unique mutations (*CYP2C19**2 and *CYP2C19**3). Although *2 can be found in all ethnic groups, *3 appears to be specific to those of Eastern Asian origin. The presence of *3 together with a higher rate of *2 is responsible for the higher rate of PMs among Asians and the resultant increased sensitivity to *CYP2C19* substrates such as diazepam (Goldstein et al. 1997) (Figure 11–5). Clinicians considering the use of diazepam in Asian populations should use the lowest possible starting dose and dose titration to avoid excessive sedation.

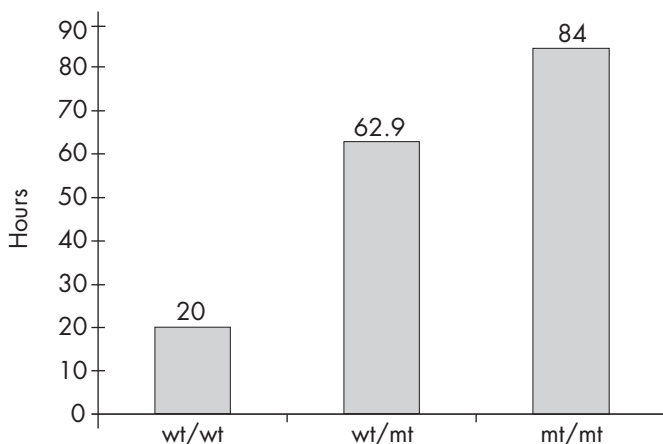


Figure 11–5. Cytochrome P450 (CYP450) 2C19 activity and half-life of diazepam in Chinese patients.

Note. mt=mutant type; wt=wild type.

Source. Qin et al. 1999.

Cytochrome P450 Enzymes and Environmental Factors

Several mechanisms are involved in the mediation of CYP450 environmental interactions, including competitive inhibition and induction. Of these, com-

petitive inhibition probably occurs most often at specific times, which could lead to serious clinical consequences. For example, as mentioned earlier, many psychotropics are substrates of CYP2D6 (e.g., SSRIs, TCAs, and neuroleptics), and each can competitively inhibit the other's metabolism when they are administered together, leading to serious consequences (Brøsen 1995) (Table 11–2). Even for a high-capacity enzyme like CYP3A4, similar clinically significant interactions could occur, as exemplified by the withdrawal of terfenadine from the market, particularly because of cases indicating its potential for serious interactions with ketoconazole (Jurima-Romet et al. 1994). Such interactions are not limited to pharmaceutical agents. They are clearly documented by the observation that grapefruit juice significantly inhibits the metabolism of several antiviral and anticancer drugs, as well as psychotropics such as nefazodone and alprazolam (Oesterheld and Kallepalli 1997), even after 96 hours (Takanaga et al. 2000). Similarly, consumption of a corn diet that consisted of tortillas and *pozole* resulted in an increased rate of side effects with nifedipine compared with the lower rate observed with a noncorn diet (Palma-Aguirre et al. 1994) (Figure 11–6).

Both CYP3A4 and CYP1A2 are highly inducible by specific pharmaceutical agents and by certain natural substances. The effect of smoking and dietary changes on CYP1A2 has been described earlier. A body of literature shows that ethnic differences in dietary practices (i.e., high-carbohydrate vs. high-protein diet) have contributed to variations in the metabolism of several drugs, including theophylline, antipyrine, and clomipramine (Anderson et al. 1991), presumably because of changes in CYP1A2 capacity. Some of these reports also showed that the dietary changes associated with acculturation have led to the amelioration of such ethnic differences.

Until recently (Eisenberg et al. 1993), very little attention has been paid to the potential of herbal medicines that affect drug-metabolizing enzymes (Tables 11–5 and 11–6), even though it is self-evident that the natural targets of these enzymes are not pharmaceuticals but potentially life-threatening products from the biological world. Herbs have always been extensively used in all human societies, and many have been found to have “real” biological effects. It is estimated that approximately one-third of modern medicines originated from herbal sources. People routinely and extensively use herbal medicines worldwide. There is a theoretical basis supported by empirical data to assume that

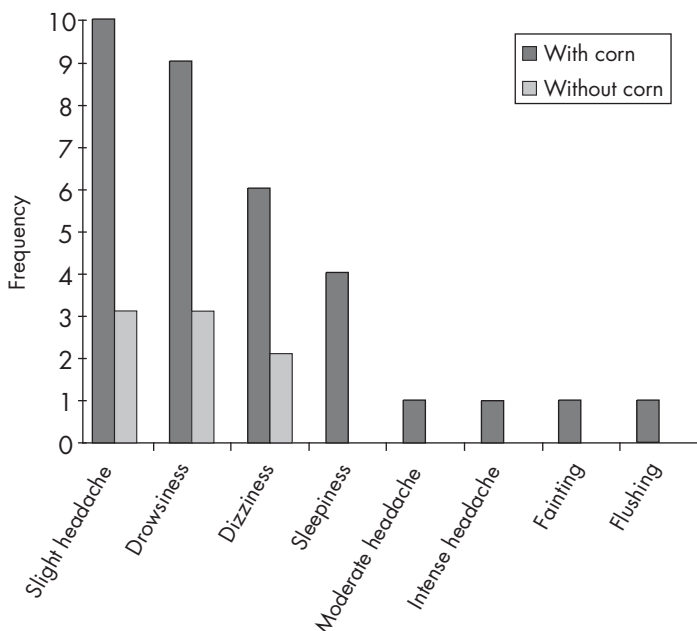


Figure 11–6. Nifedipine side effects and corn.

Source. Palma-Aguirre et al. 1994.

many of the herbs significantly modify the expression of drug-metabolizing enzymes, either by inhibition or by induction (Gurley et al. 2002). Because patients typically are not aware of the potential of herb-drug interactions, they often combine the use of herbs and Western medicines. When severe toxic effects subsequently emerge, they usually blame them on the drugs prescribed by clinicians rather than on herbal preparations obtained over the counter or from traditional or alternative practitioners (Smith et al. 1993). The potential for interaction between herbs and modern pharmaceutical agents is endless and largely unexplored. In this regard, it is likely that reports of St. John's wort (*Hypericum*) producing drastic reductions in concentrations of indinavir (Piscitelli

et al. 2000) and digoxin (Johns et al. 1999) may represent just the tip of the iceberg in terms of the magnitude of the effect of herbal preparations on ethnopsychopharmacology.

Similarly, many substances of abuse are of plant origin or are plant derivatives (e.g., ethanol, nicotine, morphine, and marijuana), and they are also metabolized through “drug-metabolizing” enzymes (Howard et al. 2002). Consequently, they have the potential to affect or to be affected by the status of particular enzymes. Many may interact with other substrates of these enzymes, including many psychotropics that are often prescribed for substance abuse and dual-diagnosis patients. Evidence also indicates that the genotypes of some of these enzymes (i.e., CYP2D6) are significantly associated with the risk and severity of dependence (Howard et al. 2002). Together, they suggest that the field of pharmacogenetics represents a promising direction for future research into substance abuse and dual diagnosis.

Xenobiotics (i.e., micronutrients, macronutrients, substances of abuse, and herbs) are natural substrates of the “drug-metabolizing” enzymes and are likely to have the potential of interacting significantly with pharmaceutical agents. However, our knowledge base in this regard is seriously deficient. Fortunately, with progress in the methodologies in pharmacogenetics, it is now possible to systematically assess such effects, with the resultant information made available to clinicians and patients. In 2012, AssureRX, YouScript, CompanionDX, and others released the first commercially available genetic screening method for testing a patient’s CYP450 profiles via a cheek swab. The testing is expensive, listed at about \$3,000 per test, but it was covered by Medicare at the time of publication. The results of such testing will enable patients and physicians to make better-informed decisions with regard to herbal medications, at least in terms of their safety when combined with “modern” medicines. Clinicians should routinely ask about the use of food supplements, herbals, and teas at the initial visit and at follow-up visits. Patients should be asked to bring in their bottles to examine the individual ingredients contained in combination products. Some reference Internet sites are available for consultation, including www.naturaldatabase.com and www.gentest.com.

Table 11–5. Herb–cytochrome P450 (CYP450) drug interactions

Drug (A)	Herbal (B)	CYP450	Interaction
Ciprofloxacin Enoxacin Pipemidic acid Fluvoxamine	<i>Coffea arabica</i> <i>Llex paullina</i> Yerba mate	1A2 inhibition	Increased concentration B Caffeine toxicity
Theophylline Phenytoin	Piper longum <i>Piper nigrum</i>	1A2 inhibition	Increased concentration A
Licorice		1A2 induction	Decreased concentration A
Quinidine Haloperidol Moclobemide	Sparteine in <i>Cytisus scoparius</i>	2D6 inhibition	Increased concentration B Circulatory collapse
Nifedipine Terfenadine, alprazolam	Grapefruit, corn, <i>Panax ginseng</i> , <i>Ginkgo biloba</i>	3A4 inhibition	Increased concentration A, increased effects
Cyclosporine Digoxin, indinavir Amitriptyline	St. John's wort, licorice	1A2, 2D6, 3A4 induction	Decreased concentration A Decreased effects

Table 11–6. Herbal medications and cytochrome P450 (CYP450) enzymes

Herbal	Action
Black pepper (<i>Piper nigrum</i>) ^a	Inhibits CYP1A2, CYP3A4 ^f
Garlic (<i>Allium sativum</i>) ^b	Inhibits CYP2E1 ^f
Green tea (<i>Camellia sinensis</i>) ^c	Inhibits CYP1A2, CYP3A4 ^f
Kava (<i>Piper methysticum</i>) ^d	Inhibits CYP1A2, CYP2C9, CYP2C19, CYP2D6, CYP3A4 ^f
St. John's wort (<i>Hypericum perforatum</i>) ^b	Induces CYP2E1 and CYP3A4 ^g
Mace, nutmeg, black pepper, Chinese cinnamon, Sri Lankan cinnamon, ginger, Japanese pepper, sage, Sichuan pepper, turmeric, and white pepper ^c	Inhibit CYP3A4 and CYP2C9 ^f

Source. ^aBhardwaj et al. 2002; ^bGurley et al. 2002; ^cMuto et al. 2001; ^dMathews et al. 2002; ^eKimura et al. 2010; ^fin vitro studies; ^gin vivo studies.

Importance of Nonpharmacological Factors

Finally, it should be emphasized that regardless of specificity and potency of any given pharmacological intervention, treatment effects are invariably even more powerfully determined by factors that are primarily nonbiological (Smith et al. 1993). These include issues related to expectations, adherence (compliance), placebo response, and clinician-patient relationships. Because they are all largely mediated through symbolic and interactive processes, there is little question that culture plays an extremely important role in shaping these responses, which powerfully determine whether a given patient will respond to a particular treatment regimen. As important as these issues are, unfortunately, they have thus far rarely been the focus of any systematic research attention, and the literature covering this important area is meager. However, data from a large variety of sources, including clinical reports, anthropological observations, and utilization studies, converge to support the thesis that cultural factors are indeed extremely important in influencing a patient's attitude, adherence, and ultimately response to pharmacological treatment. For example, among Asians and Asian Americans, there is a widespread belief in

the danger of the long-term use of “Western” medications, and this belief may contribute significantly to problems of noncompliance (Smith et al. 1993). However, without systematic research data, it remains unclear to what extent this may indeed be the case.

The therapeutic relationship is a two-way process, and the outcome of the therapeutic interaction is influenced not only by the patient but also by the clinician. In a cross-cultural situation, the clinician’s ability to accurately assess a patient’s symptoms, as well as responses to treatment, may be hampered by misperceptions and inadequate understanding of the patient’s cultural norms (Lin et al. 1993). These deficiencies of understanding are likely the reason for the higher doses of neuroleptics that are prescribed for African American patients in comparison with their white counterparts (Strickland et al. 1991). In several studies, African Americans also have been shown to have a higher rate of tardive dyskinesia (Glazer et al. 1994; Lawson 1996), which likely is related to their exposure to higher doses of neuroleptics over time. This is not an innocuous condition and deserves more careful and systematic exploration in the future. Also, the choice of medications, particularly atypical antipsychotics, should be tempered by an understanding of individual and population risk factors for medical morbidities, such as obesity, hypertension, diabetes mellitus, and cardiovascular disease. For instance, many of the reports of diabetic ketoacidosis secondary to atypical agents have been in African Americans, who are at higher risk for diabetes (Ananth et al. 2002).

Conclusion

Culture and ethnicity are powerful determinants of an individual’s response to psychopharmacotherapy. Knowledge of these factors will augment our current practice in using medications as long as we also appreciate that they are superimposed on usually very substantial interindividual variations. For this reason, it is important that any findings regarding ethnic variations in pharmacological responses not be interpreted stereotypically. However, a few generalizations may be helpful (Table 11–7).

- **Assessment:** Use the updated DSM-5 Outline for Cultural Formulation and the Cultural Formulation Interview for diagnosis and treatment planning to assess the patient’s health beliefs and practices and family dynamics.

Table 11–7. Five tips for working with ethnic minority patients

1. Start at a low dose and move up slowly.**2. Ask about diet and smoking.**

When evaluating a patient for noncompliance versus treatment resistance, always inquire about smoking, diet, and use of herbal medications.

3. Check plasma levels.

Although therapeutic plasma levels have yet to be established for many of the atypical antipsychotics, levels can be used to check for compliance.

4. Involve the family.

This is also helpful in improvement of treatment adherence.

5. Use a different drug formulation.

Several medications are now available in either liquid or “quick-dissolve” formulations.

- **Choice of medication:** Take into consideration the patient’s medical history, concurrent medications, and diet and food supplements or herbals, combined with the knowledge of enzyme activity in certain ethnic groups.
- **Monitoring patient:** Start with a low dose and proceed slowly. If side effects are intolerable, lower the dosage or choose a drug metabolized through a different route. When the patient has no response to the medication, check adherence, raise the dosage, and monitor levels. Consider adding inhibitors, such as paroxetine to risperidone or grapefruit juice to various agents, or switching drugs. Finally, consider alternative preparations, such as liquid, “quick-dissolve,” or depot formulations.
- **Systems issues:** Involve the patient’s family to improve treatment adherence.
- **Testing:** Consider using genetic testing for CYP450 profiles, if covered by the patient’s insurance.

It is hoped that many of these new technologies will become clinically available to allow for the individualization of medication intervention. Progress in this field of investigation is crucial for the provision of rational and appropriate care for patients of all ethnic and cultural backgrounds.

References

- Adebimpe VR: Overview: American blacks and psychiatry. *Transcultural Psychiatric Research Review* 21:81–109, 1984
- Agúndez JA, Ledesma MC, Ladero JM, et al: Prevalence of CYP2D6 gene duplication and its repercussion on the oxidative phenotype in a white population. *Clin Pharmacol Ther* 57(3):265–269, 1995
- Ajir K, Smith M, Lin KM, et al: The pharmacokinetics and pharmacodynamics of adinazolam: multi-ethnic comparisons. *Psychopharmacology (Berl)* 129(3):265–270, 1997
- Aklillu E, Persson I, Bertilsson L, et al: Frequent distribution of ultrarapid metabolizers of debrisoquine in an Ethiopian population carrying duplicated and multiduplicated functional CYP2D6 alleles. *J Pharmacol Exp Ther* 278(1):441–446, 1996
- Alonso M, Val E, Rapaport MH: An open-label study of SSRI treatment in depressed Hispanic and non-Hispanic women (letter). *J Clin Psychiatry* 58(1):31, 1997
- Ananth J, Venkatesh R, Burgoyne K, et al: Atypical antipsychotic drug use and diabetes. *Psychother Psychosom* 71(5):244–254, 2002
- Anderson KE, McCleery RB, Vesell ES, et al: Diet and cimetidine induce comparable changes in theophylline metabolism in normal subjects. *Hepatology* 13(5):941–946, 1991
- Bailey RK, Mallinckrodt CH, Wohlreich MM, et al: Duloxetine in the treatment of major depressive disorder: comparisons of safety and efficacy. *J Natl Med Assoc* 98(3):437–447, 2006
- Bhardwaj RK, Glaeser H, Becquemont L, et al: Piperine, a major constituent of black pepper, inhibits human P-glycoprotein and CYP3A4. *J Pharmacol Exp Ther* 302(2):645–650, 2002
- Bigos KL, Bies RR, Pollock BG, et al: Genetic variation in CYP3A43 explains racial difference in olanzapine clearance. *Mol Psychiatry* 16(6):620–625, 2011
- Blaisdell J, Mohrenweiser H, Jackson J, et al: Identification and functional characterization of new potentially defective alleles of human CYP2C19. *Pharmacogenetics* 12(9):703–711, 2002
- Brøsen K: Drug interactions and the cytochrome P450 system: the role of cytochrome P450 1A2. *Clin Pharmacokinet* 29 (suppl 1):20–25, 1995
- Carrillo JA, Benitez J: Clinically significant pharmacokinetic interactions between dietary caffeine and medications. *Clin Pharmacokinet* 39(2):127–153, 2000
- Chaudhry I, Neelam K, Duddu V, et al: Ethnicity and psychopharmacology. *J Psychopharmacol* 22(6):673–680, 2008
- Chong SA, Remington GJ, Lee N, et al: Contrasting clozapine prescribing patterns in the East and West? *Ann Acad Med Singapore* 29(1):75–78, 2000

- Collazo Y, Tam R, Sramek J, et al: Neuroleptic dosing in Hispanic and Asian inpatients with schizophrenia. *Mt Sinai J Med* 63(5–6):310–313, 1996
- Conley RR, Mahmoud R: A randomized double-blind study of risperidone and olanzapine in the treatment of schizophrenia or schizoaffective disorder. *Am J Psychiatry* 158(5):765–774, 2001
- Dahl ML, Yue QY, Roh HK, et al: Genetic analysis of the CYP2D locus in relation to debrisoquine hydroxylation capacity in Korean, Japanese and Chinese subjects. *Pharmacogenetics* 5(3):159–164, 1995
- Daumit GL, Crum RM, Guallar E, et al: Outpatient prescriptions for atypical antipsychotics for African Americans, Hispanics, and whites in the United States. *Arch Gen Psychiatry* 60(2):121–128, 2003
- Eisenberg DM, Kessler RC, Foster C, et al: Unconventional medicine in the United States: prevalence, costs, and patterns of use. *N Engl J Med* 328(4):246–252, 1993
- Escobar JI, Tuason VB: Antidepressant agents—a cross-cultural study. *Psychopharmacol Bull* 16(3):49–52, 1980
- Fleishaker JC, Hulst LK, Ekernäs SA, et al: Pharmacokinetics and pharmacodynamics of adinazolam and N-desmethylnadiazolam after oral and intravenous dosing in healthy young and elderly volunteers. *J Clin Psychopharmacol* 12(6):403–414, 1992
- Frackiewicz E, Sramek J, Collazo Y, et al: Risperidone in the treatment of Hispanic schizophrenia inpatients, in *Cross Cultural Psychiatry*. Edited by Herrera JM, Lawson WB, Sramek JJ. West Sussex, UK, Wiley, 1999, pp 183–192
- Gaedigk A, Gotschall RR, Forbes NS, et al: Optimization of cytochrome P4502D6 (CYP2D6) phenotype assignment using a genotyping algorithm based on allele frequency data. *Pharmacogenetics* 9(6):669–682, 1999
- Gaviria M, Gil AA, Javadi JI: Nortriptyline kinetics in Hispanic and Anglo subjects. *J Clin Psychopharmacol* 6(4):227–231, 1986
- Ghoneim MM, Korttila K, Chiang CK, et al: Diazepam effects and kinetics in Caucasians and Orientals. *Clin Pharmacol Ther* 29(6):749–756, 1981
- Glazer WM, Morgenstern H, Doucette J: Race and tardive dyskinesia among outpatients at a CMHC. *Hosp Community Psychiatry* 45(1):38–42, 1994
- Goldstein JA, Ishizaki T, Chiba K, et al: Frequencies of the defective CYP2C19 alleles responsible for the mephenytoin poor metabolizer phenotype in various Oriental, Caucasian, Saudi Arabian and American black populations. *Pharmacogenetics* 7(1):59–64, 1997
- Gonzalez FJ, Nebert DW: Evolution of the P450 gene superfamily: animal-plant ‘warfare,’ molecular drive and human genetic differences in drug oxidation. *Trends Genet* 6(6):182–186, 1990

- Gurley BJ, Gardner SF, Hubbard MA, et al: Cytochrome P450 phenotypic ratios for predicting herb-drug interactions in humans. *Clin Pharmacol Ther* 72(3):276–287, 2002
- Henderson DC, Nguyen DD, Copeland PM, et al: Clozapine, diabetes mellitus, hyperlipidemia, and cardiovascular risks and mortality: results of a 10-year naturalistic study. *J Clin Psychiatry* 66(9):1116–1121, 2005
- Howard LA, Sellers EM, Tyndale RF: The role of pharmacogenetically variable cytochrome P450 enzymes in drug abuse and dependence. *Pharmacogenomics* 3(2):185–199, 2002
- Hsieh KP, Lin YY, Cheng CL, et al: Novel mutations of CYP3A4 in Chinese. *Drug Metab Dispos* 29(3):268–273, 2001
- Ioannides C: Effect of diet and nutrition on the expression of cytochromes P450. *Xenobiotica* 29(2):109–154, 1999
- Ishigooka J, Murasaki M, Miura S; Olanzapine Early Phase II Study Group: Efficacy and safety of olanzapine, an atypical antipsychotic, in patients with schizophrenia: results of an open-label multicenter study in Japan. *Psychiatry Clin Neurosci* 55(4):353–363, 2001
- Jann MW, Lam YWF, Chang WH: Haloperidol and reduced haloperidol plasma concentrations in different ethnic populations and interindividual variabilities in haloperidol metabolism, in *Psychopharmacology and Psychobiology of Ethnicity*. Edited by Lin KM, Poland RE, Nakasaki G. Washington, DC, American Psychiatric Press, 1993, pp 133–152
- Jin H, Meyer JM, Jeste DV: Phenomenology of and risk factors for new-onset diabetes mellitus and diabetic ketoacidosis associated with atypical antipsychotics: an analysis of 45 published cases. *Ann Clin Psychiatry* 14(1):59–64, 2002
- Johne A, Brockmöller J, Bauer S, et al: Pharmacokinetic interaction of digoxin with an herbal extract from St John's wort (*Hypericum perforatum*). *Clin Pharmacol Ther* 66(4):338–345, 1999
- Johnson JA: Predictability of the effects of race or ethnicity on pharmacokinetics of drugs. *Int J Clin Pharmacol Ther* 38(2):53–60, 2000
- Juarez-Reyes MG, Shumway M, Battle C, et al: Clozapine eligibility: the effect of stringent criteria on ethnic, gender and age subgroups of schizophrenic patients. *Prog Neuropsychopharmacol Biol Psychiatry* 20(8):1341–1352, 1996
- Jurima-Romet M, Crawford K, Cyr T, et al: Terfenadine metabolism in human liver: in vitro inhibition by macrolide antibiotics and azole antifungals. *Drug Metab Dispos* 22(6):849–857, 1994
- Kalow W (ed): *Pharmacogenetics of Drug Metabolism*. New York, Pergamon, 1992

- Kelly DL, Kreyenbuhl J, Dixon L, et al: Clozapine underutilization and discontinuation in African Americans due to leucopenia. *Schizophr Bull* 33(5):1221–1224, 2007
- Kimura Y, Ito H, Hatano T: Effects of mace and nutmeg on human cytochrome P450 3A4 and 2C9 activity. *Biol Pharm Bull* 33(12):1977–1982, 2010
- Kinirons MT, Lang CC, He HB, et al: Triazolam pharmacokinetics and pharmacodynamics in Caucasians and Southern Asians: ethnicity and CYP3A activity. *Br J Clin Pharmacol* 41(1):69–72, 1996
- Kobayashi K, Chiba K, Yagi T, et al: Identification of cytochrome P450 isoforms involved in citalopram N-demethylation by human liver microsomes. *J Pharmacol Exp Ther* 280(2):927–933, 1997
- Kuno E, Rothbard AB: Racial disparities in antipsychotic prescription patterns for patients with schizophrenia. *Am J Psychiatry* 159(4):567–572, 2002
- Lane H, Jann M, Liu H, et al: Olanzapine pharmacokinetics in Chinese schizophrenic patients: comparable with Caucasians. Presented at the Pacific Rim Association for Clinical Pharmacogenetics Meeting. Taipei City, Taiwan, April 1999a
- Lane H, Chiu W, Chen C: Risperidone dosing in acutely exacerbated schizophrenia: higher plasma levels in Chinese. Presented at the Pacific Rim Association for Clinical Pharmacogenetics Meeting. Taipei City, Taiwan, April 1999b
- Lawson WB: Clinical issues in the pharmacotherapy of African-Americans. *Psychopharmacol Bull* 32(2):275–281, 1996
- Leathart JB, London SJ, Steward A, et al: CYP2D6 phenotype-genotype relationships in African-Americans and Caucasians in Los Angeles. *Pharmacogenetics* 8(6):529–541, 1998
- Lessard E, Yessine MA, Hamelin BA, et al: Influence of CYP2D6 activity on the disposition and cardiovascular toxicity of the antidepressant agent venlafaxine in humans. *Pharmacogenetics* 9(4):435–443, 1999
- Lesser IM, Smith MW, Wohl M, et al: Brain imaging, antidepressants, and ethnicity: preliminary observations. *Psychopharmacol Bull* 32(2):235–242, 1996
- Lin KM, Cheung F: Mental health issues for Asian Americans. *Psychiatr Serv* 50(6):774–780, 1999
- Lin KM, Lau JK, Smith R, et al: Comparison of alprazolam plasma levels in normal Asian and Caucasian male volunteers. *Psychopharmacology (Berl)* 96(3):365–369, 1988
- Lin KM, Poland RE, Nuccio I, et al: A longitudinal assessment of haloperidol doses and serum concentrations in Asian and Caucasian schizophrenic patients. *Am J Psychiatry* 146:1307–1311, 1989
- Lin KM, Poland RE, Nakasaki G (eds): *Psychopharmacology and Psychobiology of Ethnicity*. Washington, DC, American Psychiatric Press, 1993

- Livingston RL, Zucker DK, Isenberg K, et al: Tricyclic antidepressants and delirium. *J Clin Psychiatry* 44(5):173–176, 1983
- Lu FG, Chien CP, Heming G, et al: Ethnicity and neuroleptic drug dosage. Poster presented at the 140th annual meeting of the American Psychiatric Association. Chicago, IL, May 9–15, 1987
- Lundqvist E, Johansson I, Ingelman-Sundberg M: Genetic mechanisms for duplication and multiduplication of the human CYP2D6 gene and methods for detection of duplicated CYP2D6 genes. *Gene* 226(2):327–338, 1999
- Marcos LR, Cancro R: Pharmacotherapy of Hispanic depressed patients: clinical observations. *Am J Psychother* 36(2):505–512, 1982
- Masimirembwa CM, Hasler JA: Genetic polymorphism of drug metabolising enzymes in African populations: implications for the use of neuroleptics and antidepressants. *Brain Res Bull* 44(5):561–571, 1997
- Masimirembwa CM, Johansson L, Bertilsson L, et al: Diminished enzyme activity and lack of metabolic correlation of CYP2D6 probe drugs in a black Zimbabwean (Shona) population, in *Pharmacogenetics of Drug Metabolizing Enzymes in a Black African Population*. Edited by Masimirembwa CM. Stockholm, Karolinska Institutet, 1995, pp 1–21
- Mathews JM, Etheridge AS, Black SR: Inhibition of human cytochrome P450 activities by kava extract and kavalactones. *Drug Metab Dispos* 30(11):1153–1157, 2002
- Matsuda KT, Cho MC, Lin KM, et al: Clozapine dosage, serum levels, efficacy, and side-effect profiles: a comparison of Korean-American and Caucasian patients. *Psychopharmacol Bull* 32(2):253–257, 1996
- McLellan RA, Oscarson M, Seidegård J, et al: Frequent occurrence of CYP2D6 gene duplication in Saudi Arabians. *Pharmacogenetics* 7(3):187–191, 1997
- Melfi CA, Croghan TW, Hanna MP, et al: Racial variation in antidepressant treatment in a Medicaid population. *J Clin Psychiatry* 61(1):16–21, 2000
- Mendoza R, Wan YJ, Poland RE, et al: CYP2D6 polymorphism in a Mexican American population. *Clin Pharmacol Ther* 70(6):552–560, 2001
- Meyer MC, Baldessarini RJ, Goff DC, et al: Clinically significant interactions of psychotropic agents with antipsychotic drugs. *Drug Saf* 15(5):333–346, 1996
- Meyer UA: Pharmacogenetics: the slow, the rapid, and the ultrarapid. *Proc Natl Acad Sci U S A* 91(6):1983–1984, 1994
- Muto S, Fujita K, Yamazaki Y, et al: Inhibition by green tea catechins of metabolic activation of procarcinogens by human cytochrome P450. *Mutat Res* 479(1–2):197–206, 2001

- Naoe T, Takeyama K, Yokozawa T, et al: Analysis of genetic polymorphism in NQO1, GST-M1, GST-T1, and CYP3A4 in 469 Japanese patients with therapy-related leukemia/myelodysplastic syndrome and de novo acute myeloid leukemia. *Clin Cancer Res* 6(10):4091–4095, 2000
- Oosterheld J, Kallepalli BR: Grapefruit juice and clomipramine: shifting metabolic ratios. *J Clin Psychopharmacol* 17(1):62–63, 1997
- Palma-Aguirre JA, Nava Rangel J, Hoyo-Vadillo C, et al: Influence of Mexican diet on nifedipine pharmacodynamics in healthy volunteers. *Proc West Pharmacol Soc* 37:85–86, 1994
- Piscitelli SC, Burstein AH, Chait D, et al: Indinavir concentrations and St John's wort. *Lancet* 355(9203):547–548, 2000
- Pollock BG, Perel JM, Kirshner M, et al: S-mephenytoin 4-hydroxylation in older Americans. *Eur J Clin Pharmacol* 40(6):609–611, 1991
- Potkin SG, Shen Y, Pardes H, et al: Haloperidol concentrations elevated in Chinese patients. *Psychiatry Res* 12(2):167–172, 1984
- Qin XP, Xie HG, Wang W, et al: Effect of the gene dosage of CgammaP2C19 on diazepam metabolism in Chinese subjects. *Clin Pharmacol Ther* 66(6):642–646, 1999
- Ramirez LF: Ethnicity and psychopharmacology in Latin America. *Mt Sinai J Med* 63(5–6):330–331, 1996
- Relling MV, Lin JS, Ayers GD, et al: Racial and gender differences in N-acetyltransferase, xanthine oxidase, and CYP1A2 activities. *Clin Pharmacol Ther* 52(6):643–658, 1992
- Sachse C, Brockmöller J, Bauer S, et al: Functional significance of a C→A polymorphism in intron 1 of the cytochrome P450 CYP1A2 gene tested with caffeine. *Br J Clin Pharmacol* 47(4):445–449, 1999
- Schein JR: Cigarette smoking and clinically significant drug interactions. *Ann Pharmacother* 29(11):1139–1148, 1995
- Silver B, Lin KM, Poland RE: Ethnicity and the pharmacology of tricyclic antidepressants, in *Psychopharmacology and Psychobiology of Ethnicity*. Edited by Lin KM, Poland RE, Nakasaki G. Washington, DC, American Psychiatric Press, 1993, pp 61–89
- Smith MW, Mendoza RP: Ethnicity and pharmacogenetics. *Mt Sinai J Med* 63(5–6):285–290, 1996
- Smith M, Lin KM, Mendoza RL: “Nonbiological” issues affecting psychopharmacotherapy: cultural considerations, in *Psychopharmacology and Psychobiology of Ethnicity*. Edited by Lin KM, Poland RE, Nakasaki G. Washington, DC, American Psychiatric Press, 1993, pp 37–58

- Sowunmi A, Rashid TJ, Akinyinka OO, et al: Ethnic differences in nifedipine kinetics: comparisons between Nigerians, Caucasians and South Asians. *Br J Clin Pharmacol* 40(5):489–493, 1995
- Strickland TL, Ranganath V, Lin KM, et al: Psychopharmacologic considerations in the treatment of black American populations. *Psychopharmacol Bull* 27(4):441–448, 1991
- Takanaga H, Ohnishi A, Murakami H, et al: Relationship between time after intake of grapefruit juice and the effect on pharmacokinetics and pharmacodynamics of nifedipine in healthy subjects. *Clin Pharmacol Ther* 67(3):201–214, 2000
- Wagner GJ, Maguen S, Rabkin JG: Ethnic differences in response to fluoxetine in a controlled trial with depressed HIV-positive patients. *Psychiatr Serv* 49(2):239–240, 1998
- Wang JH, Liu ZQ, Wang W, et al: Pharmacokinetics of sertraline in relation to genetic polymorphism of CYP2C19. *Clin Pharmacol Ther* 70(1):42–47, 2001
- Whiskey E, Olofinjana O, Taylor D: The importance of the recognition of benign ethnic neutropenia in black patients during treatment with clozapine: case reports and database study. *J Psychopharmacol* 25(6):842–845, 2011

Conclusion

Applying the Updated DSM-5 Outline for Cultural Formulation and Cultural Formulation Interview

Russell F. Lim, M.D., M.Ed.

Culturally appropriate psychiatric assessment is complex and challenging. However, some general themes emerge after reviewing chapters on the four major ethnic groups and chapters on women, sexual orientation, and religion and spirituality. I organize these themes according to the DSM-5 (American Psychiatric Association 2013) Outline for Cultural Formulation (OCF), beginning with the general principles.

The most useful generalization is that not all patients fit a profile or syndrome as the rest of DSM-5 would have us believe. Psychiatric assessment is often taught as if everyone has the same general background and the major differences are socioeconomic. Every group has a history, which will color in-

teractions with clinicians belonging to particular ethnic groups, such as Native Americans and African Americans interacting with whites or homosexuals interacting with heterosexuals. Identifying with and belonging to a particular ethnic group bring with them a set of values, health beliefs, and expectations of the individual and the family that are usually different from the Western norms of rapid individuation by age 18. Therefore, the information in this manual has been presented to the clinician to provide a starting point to see how an individual patient differs from other members of his or her cultural reference group.

Outline for Cultural Formulation

Cultural Identity of the Individual

Understanding cultural identity is like hearing someone say “I’m depressed” and then asking the person, “What do you mean?” The important thing is not which group patients state that they belong to but what membership in that group *means* to them. The individual’s relationship to the group can affect his or her relationship with you and can help you ask clarifying questions and rule in or rule out the relevance of various generalizations that you may have made about that group.

Cultural identity can be understood as a multifaceted core set of identities that contributes to how an individual understands his or her environment. Ethnic identity is often a crucial facet of an individual’s overall cultural identity, but many other facets may contribute to identity as well. The greater the amount of detail that a clinician is able to gather about the individual’s cultural identity, the better the understanding he or she will have about the individual’s perspective on health, illness, and the mental health system. Moreover, the clinician will more readily anticipate issues related to cultural and identity conflicts that may arise during the course of evaluation and treatment. Some commonalities that emerged from among the four groups discussed in this book are a divergence from the Western value of individualism and a convergence on the family as the central unit, its needs coming before those of the individual. Religion is a cross-cutting issue because many individuals have active spiritual lives that may support them during times of stress, but religion may cause distress if individuals are not able to practice their be-

liefs or find that their spiritual community is not in support of their problem, such as not being supportive of homosexuality. Gender identity and sexual orientation development were also found to be more complex than what might be seen on the surface.

Cultural Conceptualizations of Distress

Again, knowing a patient's cultural group provides only a starting point for exploring his or her cultural beliefs about his or her illness. Exploring these beliefs requires sensitivity to subtle nuances of the patient's culture of origin and acceptance of differing points of view. We have learned about cultural concepts of distress such as *shenjing shuairuo* and *ataque de nervios*, the significance of rootworm and hoodoo for African Americans, various Asian belief systems such as the concepts of *yin* and *yang*, alternative healing practices such as coin-ing and acupuncture, and herbal medicine. In addition, we have become aware of folk healers such as the Latino *curanderos* and conditions such as *mal de ojo*. African Americans have strong beliefs in the central role of religion in their lives and also believe that one should be able to fix one's own problems. "I'll put it in the Lord's hands" was cited as an example of these beliefs. One set of beliefs common to some Latinos and African Americans is *santería*, as seen in Cuba, and *espiritismo*, as seen in Puerto Rico. A cultural consultant or broker can be invaluable and can help the clinician to identify normative behaviors and beliefs in patients whose ethnicity differs from the clinician's. We have also seen that many ethnic minority groups express their symptoms somatically, perhaps to avoid the stigma of a mental illness, or express their illness holistically, given that most believe that psyche, soma, and spirit are one. In fact, only Western biomedicine artificially separates body and mind.

Psychosocial Stressors and Cultural Features of Vulnerability and Resilience

We have seen throughout the four chapters on ethnic groups the central importance of the family, in contrast to the Western ideal of individuation and independence. All four groups share a respect for the elders and act in accordance with family wishes and needs. Some groups have a hierarchical structure with clearly defined roles for each individual according to their age and gender. For example, Asian cultures tend to be patriarchal, in contrast to African

American cultural groups, which tend to be matriarchal. We have also seen specific gender roles in Latinos, with some male Latino patients displaying aspects of *machismo* and some Latino women displaying aspects of *marianismo*. The consequences of intergenerational conflicts were also discussed. Such conflict is most often seen in second-generation children who live in an environment steeped in old-world values yet go to school and work in a setting of Western values, often leading to involvement in gang activities.

Cultural Features of the Relationship Between the Individual and the Clinician

Each patient and each clinician brings his or her own cultural identity, beliefs, and values system into the clinical encounter, and the preceding chapters have outlined various approaches to bridging the gap between them. The clinician needs to develop an awareness of his or her own cultural identity, prejudices, and biases. Then the clinician can approach the patient in a nonjudgmental manner and explore the meaning of his or her symptoms and the behavior observed between the patient and the clinician.

We have seen how historical and personal experience with racism can lead to distance between non-ethnically matched therapists and patients, just as we see idealization and denial between ethnically matched patients and therapists. Patients from disparate ethnic groups have a wide variety of communication styles. Clinicians need to be aware of the range of normative styles for an ethnic group to best choose their interview style and to assess the patient's thought processes and cognitive status. Other factors that may influence the relationship between the therapist and the patient include religion, skin color, sexual orientation, gender, age, language, and level of acculturation. The patient may also expect the clinician to be authoritarian and directive, whereas the clinician may consider his or her role to be that of a consultant and adopt a collaborative mode, creating a mismatch. Expectations that the clinician will be more directive are most often seen in less acculturated immigrants, Native Americans, and Asian Americans. Other patients, such as many Latinos, expect their clinician to be warm and friendly (i.e., to embody *personalismo*), not detached and clinical.

We also have seen that much attention should be given to the language in which the interview is conducted and to who does the interpreting. In addi-

tion, the similarities and differences in ethnicity between therapists and their patients create patterns of relating through transference and countertransference that are predictable and describable, which allows clinicians to modify their therapeutic approach accordingly.

Overall Cultural Assessment

Developing a culturally appropriate treatment plan for an ethnic minority patient requires the integration of Western values and ethnic and cultural beliefs. After the appropriate data have been gathered using questions from the Cultural Formulation Interview (CFI), consultation with family and cultural consultants can help to bridge the gap between the clinician's and the patient's cultures. Medication dosages may be adjusted downward on the basis of the patient's ethnicity and clinical response. A common suggestion for therapists engaging in psychotherapy with ethnic minority patients was that the clinician use a directive, problem-solving approach, as opposed to the Western consultative/collaborative model. A key element of the treatment plan is for the clinician to take an attitude of acceptance of the patient's explanatory models to use those models in discussing the treatment with the patient. In addition, dosages of medication must be adjusted to reflect the patient's diet, smoking habits, and ethnicity. As treatment progresses, the plan must remain dynamic to incorporate newly found clinical information, and the clinician must monitor the patient's adherence to the treatment regimen. Only through repeated experience can we hope to master the subtleties of culturally appropriate diagnosis and treatment.

Cultural Formulation Interview

The CFI is an important advance in cultural assessment, expanding on the OCF and giving clinicians sample questions that they can elaborate on or modify for their particular purposes. The core CFI's 16 questions provide the framework for a more comprehensive interview by providing branch points to use in the 12 supplementary modules: 1) Explanatory Model; 2) Level of Functioning; 3) Social Network; 4) Psychosocial Stressors; 5) Spirituality, Religion, and Moral Traditions; 6) Cultural Identity; 7) Coping and Help-Seeking; 8) Patient-Clinician Relationship; 9) School-Age Children and Ad-

olescents; 10) Older Adults; 11) Immigrants and Refugees; and 12) Caregivers (see Appendix 1, “DSM-5 Outline for Cultural Formulation, Cultural Formulation Interview, and Supplementary Modules”). The CFI works well within the context of the DSM-5 OCF.

Final Thoughts

- When patients talk about their cultural identity, they do not tell clinicians directly what their cultural identity is, but through culturally informed questioning during the developmental and social history, the clinician can gain an understanding of patients’ cultural identity and their relationships or lack thereof with others in their family and community. By observing the interaction between the patient and himself or herself, the clinician can be sensitive to transference reactions that will impede the development of a therapeutic alliance.
- Many of the patients discussed feel isolated. Many of their family members are geographically distant from them, have died, or cannot offer support for the patient because they have changed by their acculturation to the United States or have converted to another religion or social class.
- Many patients also share the theme of ambivalence. They know the values of their culture of origin, but they have changed in some ways and not changed in others. As a result, they may not hold the same values they had previously. Because of their minority status, class, or level of acculturation, they may not fit in well with new support systems.
- A cultural consultant can be very helpful in understanding the patient’s presentation. This individual could be an interpreter, a case manager, a counselor, or a supervisor. Written sources such as the chapters in *Ethnicity and Family Therapy*, third edition (McGoldrick et al. 2005) can also be helpful. Also, it is important to understand cultural differences among groups who may speak the same language but be quite different culturally or ethnically.
- Finally, most of the patients discussed reacted to the differences between themselves and their therapists. They all believed that a white therapist would have trouble understanding their lives because the therapist might not have the same life experience, and most preferred a clinician more sim-

ilar to themselves. In all of the cases, the therapist was able to convey both some familiarity with the patient's cultural experience and a willingness to learn and try to understand. Having a different religious, cultural, or ethnic background or a different sexual orientation, gender, or gender identity from the patient does not have to be a liability and, in some cases, may be an asset.

The DSM-5 OCF and CFI are useful tools for culturally informed assessment. The OCF provides an organizing principle that can guide the culturally sensitive clinician to ask questions that will inform him or her of the patient's cultural identity, including cultural values and role in the family, as well as cultural conceptualizations of distress. The OCF also alerts the clinician to be aware of any transference by the patient resulting from perceived differences between himself or herself and the therapist. The CFI offers sample questions that can elicit culturally rich information, and the OCF allows the clinician to create an overall cultural formulation that can guide both consultation and treatment planning.

References

- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Washington, DC, American Psychiatric Association, 2013
- McGoldrick M, Giordano J, Garcia-Prero N (eds): Ethnicity and Family Therapy, 3rd Edition. New York, Guilford, 2005

This page intentionally left blank

DSM-5 Outline for Cultural Formulation, Cultural Formulation Interview, and Supplementary Modules

Outline for Cultural Formulation

The Outline for Cultural Formulation introduced in DSM-IV provided a framework for assessing information about cultural features of an individual's mental health problem and how it relates to a social and cultural context and history. DSM-5 not only includes an updated version of the Outline but also presents an approach to assessment, using the Cultural Formulation Interview (CFI), which has been field-tested for diagnostic usefulness among clinicians and for acceptability among patients.

The revised Outline for Cultural Formulation calls for systematic assessment of the following categories:

- **Cultural identity of the individual:** Describe the individual's racial, ethnic, or cultural reference groups that may influence his or her relationships with others, access to resources, and developmental and current challenges, conflicts, or predicaments. For immigrants and racial or ethnic minorities, the degree and kinds of involvement with both the culture of origin and

Reprinted from the *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition, Washington, DC, American Psychiatric Association, 2013. Used with permission. Copyright © 2013 American Psychiatric Association.

the host culture or majority culture should be noted separately. Language abilities, preferences, and patterns of use are relevant for identifying difficulties with access to care, social integration, and the need for an interpreter. Other clinically relevant aspects of identity may include religious affiliation, socioeconomic background, personal and family places of birth and growing up, migrant status, and sexual orientation.

- **Cultural conceptualizations of distress:** Describe the cultural constructs that influence how the individual experiences, understands, and communicates his or her symptoms or problems to others. These constructs may include cultural syndromes, idioms of distress, and explanatory models or perceived causes. The level of severity and meaning of the distressing experiences should be assessed in relation to the norms of the individual's cultural reference groups. Assessment of coping and help-seeking patterns should consider the use of professional as well as traditional, alternative, or complementary sources of care.
- **Psychosocial stressors and cultural features of vulnerability and resilience:** Identify key stressors and supports in the individual's social environment (which may include both local and distant events) and the role of religion, family, and other social networks (e.g., friends, neighbors, coworkers) in providing emotional, instrumental, and informational support. Social stressors and social supports vary with cultural interpretations of events, family structure, developmental tasks, and social context. Levels of functioning, disability, and resilience should be assessed in light of the individual's cultural reference groups.
- **Cultural features of the relationship between the individual and the clinician:** Identify differences in culture, language, and social status between an individual and clinician that may cause difficulties in communication and may influence diagnosis and treatment. Experiences of racism and discrimination in the larger society may impede establishing trust and safety in the clinical diagnostic encounter. Effects may include problems eliciting symptoms, misunderstanding of the cultural and clinical significance of symptoms and behaviors, and difficulty establishing or maintaining the rapport needed for an effective clinical alliance.
- **Overall cultural assessment:** Summarize the implications of the components of the cultural formulation identified in earlier sections of the Outline for diagnosis and other clinically relevant issues or problems as well as appropriate management and treatment intervention.

Cultural Formulation Interview (CFI)

The Cultural Formulation Interview (CFI) is a set of 16 questions that clinicians may use to obtain information during a mental health assessment about the impact of culture on key aspects of an individual's clinical presentation and care. In the CFI, *culture* refers to

- The values, orientations, knowledge, and practices that individuals derive from membership in diverse social groups (e.g., ethnic groups, faith communities, occupational groups, veterans groups).
- Aspects of an individual's background, developmental experiences, and current social contexts that may affect his or her perspective, such as geographical origin, migration, language, religion, sexual orientation, or race/ethnicity.
- The influence of family, friends, and other community members (the individual's *social network*) on the individual's illness experience.

The CFI is a brief semistructured interview for systematically assessing cultural factors in the clinical encounter that may be used with any individual. The CFI focuses on the individual's experience and the social contexts of the clinical problem. The CFI follows a person-centered approach to cultural assessment by eliciting information from the individual about his or her own views and those of others in his or her social network. This approach is designed to avoid stereotyping, in that each individual's cultural knowledge affects how he or she interprets illness experience and guides how he or she seeks help. Because the CFI concerns the individual's personal views, there are no right or wrong answers to these questions. The interview follows and is available online at www.psychiatry.org/dsm5.

The CFI is formatted as two text columns. The left-hand column contains the instructions for administering the CFI and describes the goals for each interview domain. The questions in the right-hand column illustrate how to explore these domains, but they are not meant to be exhaustive. Follow-up questions may be needed to clarify individuals' answers. Questions may be rephrased as needed. The CFI is intended as a guide to cultural assessment and should be used flexibly to maintain a natural flow of the interview and rapport with the individual.

The CFI is best used in conjunction with demographic information obtained prior to the interview in order to tailor the CFI questions to address the individual's background and current situation. Specific demographic domains to be explored

with the CFI will vary across individuals and settings. A comprehensive assessment may include place of birth, age, gender, racial/ethnic origin, marital status, family composition, education, language fluencies, sexual orientation, religious or spiritual affiliation, occupation, employment, income, and migration history.

The CFI can be used in the initial assessment of individuals in all clinical settings, regardless of the cultural background of the individual or of the clinician. Individuals and clinicians who appear to share the same cultural background may nevertheless differ in ways that are relevant to care. The CFI may be used in its entirety, or components may be incorporated into a clinical evaluation as needed. The CFI may be especially helpful when there is

- Difficulty in diagnostic assessment owing to significant differences in the cultural, religious, or socioeconomic backgrounds of clinician and the individual.
- Uncertainty about the fit between culturally distinctive symptoms and diagnostic criteria.
- Difficulty in judging illness severity or impairment.
- Disagreement between the individual and clinician on the course of care.
- Limited engagement in and adherence to treatment by the individual.

The CFI emphasizes four domains of assessment: Cultural Definition of the Problem (questions 1–3); Cultural Perceptions of Cause, Context, and Support (questions 4–10); Cultural Factors Affecting Self-Coping and Past Help Seeking (questions 11–13); and Cultural Factors Affecting Current Help Seeking (questions 14–16). Both the person-centered process of conducting the CFI and the information it elicits are intended to enhance the cultural validity of diagnostic assessment, facilitate treatment planning, and promote the individual's engagement and satisfaction. To achieve these goals, the information obtained from the CFI should be integrated with all other available clinical material into a comprehensive clinical and contextual evaluation. An Informant version of the CFI can be used to collect collateral information on the CFI domains from family members or caregivers.

Supplementary modules have been developed that expand on each domain of the CFI and guide clinicians who wish to explore these domains in greater depth. Supplementary modules have also been developed for specific populations, such as children and adolescents, elderly individuals, and immigrants and

refugees. These supplementary modules are referenced in the CFI under the pertinent subheadings and are available online at www.psychiatry.org/dsm5.

Cultural Formulation Interview (CFI)

Supplementary modules used to expand each CFI subtopic are noted in parentheses.

GUIDE TO INTERVIEWER

The following questions aim to clarify key aspects of the presenting clinical problem from the point of view of the individual and other members of the individual's social network (i.e., family, friends, or others involved in current problem). This includes the problem's meaning, potential sources of help, and expectations for services.

INSTRUCTIONS TO THE INTERVIEWER ARE ITALICIZED.

INTRODUCTION FOR THE INDIVIDUAL:

I would like to understand the problems that bring you here so that I can help you more effectively. I want to know about *your* experience and ideas. I will ask some questions about what is going on and how you are dealing with it. Please remember there are no right or wrong answers.

CULTURAL DEFINITION OF THE PROBLEM

CULTURAL DEFINITION OF THE PROBLEM

(Explanatory Model, Level of Functioning)

Elicit the individual's view of core problems and key concerns.

Focus on the individual's own way of understanding the problem.

Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (e.g., "your conflict with your son").

Ask how individual frames the problem for members of the social network.

Focus on the aspects of the problem that matter most to the individual.

1. What brings you here today?
IF INDIVIDUAL GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE:

People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would *you* describe your problem?

2. Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them?
3. What troubles you most about your problem?

Cultural Formulation Interview (CFI) (*continued*)

Supplementary modules used to expand each CFI subtopic are noted in parentheses.

GUIDE TO INTERVIEWER **INSTRUCTIONS TO THE INTERVIEWER ARE *ITALICIZED*.**

CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT

CAUSES

(Explanatory Model, Social Network, Older Adults)

This question indicates the meaning of the condition for the individual, which may be relevant for clinical care.

Note that individuals may identify multiple causes, depending on the facet of the problem they are considering.

Focus on the views of members of the individual's social network. These may be diverse and vary from the individual's.

4. Why do you think this is happening to you? What do you think are the causes of your [PROBLEM]?

PROMPT FURTHER IF REQUIRED:

Some people may explain their problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes.

5. What do others in your family, your friends, or others in your community think is causing your [PROBLEM]?

STRESSORS AND SUPPORTS

(Social Network, Caregivers, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Cultural Identity, Older Adults, Coping and Help Seeking)

Elicit information on the individual's life context, focusing on resources, social supports, and resilience. May also probe other supports (e.g., from co-workers, from participation in religion or spirituality).

Focus on stressful aspects of the individual's environment. Can also probe, e.g., relationship problems, difficulties at work or school, or discrimination.

6. Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others?

7. Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with money, or family problems?

Cultural Formulation Interview (CFI) (*continued*)

Supplementary modules used to expand each CFI subtopic are noted in parentheses.

GUIDE TO INTERVIEWER	INSTRUCTIONS TO THE INTERVIEWER ARE <i>ITALICIZED</i>.
-----------------------------	---

ROLE OF CULTURAL IDENTITY

(Cultural Identity, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Older Adults, Children and Adolescents)

Sometimes, aspects of people's background or identity can make their [PROBLEM] better or worse. By *background* or *identity*, I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, or your faith or religion.

Ask the individual to reflect on the most salient elements of his or her cultural identity. Use this information to tailor questions 9–10 as needed.

Elicit aspects of identity that make the problem better or worse.

Probe as needed (e.g., clinical worsening as a result of discrimination due to migration status, race/ethnicity, or sexual orientation).

Probe as needed (e.g., migration-related problems; conflict across generations or due to gender roles).

8. For you, what are the most important aspects of your background or identity?
9. Are there any aspects of your background or identity that make a difference to your [PROBLEM]?
10. Are there any aspects of your background or identity that are causing other concerns or difficulties for you?

Cultural Formulation Interview (CFI) (*continued*)

Supplementary modules used to expand each CFI subtopic are noted in parentheses.

GUIDE TO INTERVIEWER **INSTRUCTIONS TO THE INTERVIEWER ARE *ITALICIZED*.**

CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING

SELF-COPING

(Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors)

Clarify self-coping for the problem.

11. Sometimes people have various ways of dealing with problems like [PROBLEM]. What have you done on your own to cope with your [PROBLEM]?

PAST HELP SEEKING

(Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship)

Elicit various sources of help (e.g., medical care, mental health treatment, support groups, work-based counseling, folk healing, religious or spiritual counseling, other forms of traditional or alternative healing).

Probe as needed (e.g., "What other sources of help have you used?").

Clarify the individual's experience and regard for previous help.

12. Often, people look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have you sought for your [PROBLEM]?

PROBE IF DOES NOT DESCRIBE USEFULNESS OF HELP RECEIVED:

What types of help or treatment were most useful? Not useful?

Cultural Formulation Interview (CFI) (continued)

Supplementary modules used to expand each CFI subtopic are noted in parentheses.

GUIDE TO INTERVIEWER INSTRUCTIONS TO THE INTERVIEWER ARE *ITALICIZED*.

BARRIERS

(Coping and Help Seeking, Religion and Spirituality, Older Adults, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship)

Clarify the role of social barriers to help seeking, access to care, and problems engaging in previous treatment.

Probe details as needed (e.g., "What got in the way?").

13. Has anything prevented you from getting the help you need?

PROBE AS NEEDED:

For example, money, work or family commitments, stigma or discrimination, or lack of services that understand your language or background?

CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING

PREFERENCES

(Social Network, Caregivers, Religion and Spirituality, Older Adults, Coping and Help Seeking)

Clarify individual's current perceived needs and expectations of help, broadly defined.

Probe if individual lists only one source of help (e.g., "What other kinds of help would be useful to you at this time?").

Focus on the views of the social network regarding help seeking.

Now let's talk some more about the help you need.

14. What kinds of help do you think would be most useful to you at this time for your [PROBLEM]?

15. Are there other kinds of help that your family, friends, or other people have suggested would be helpful for you now?

Cultural Formulation Interview (CFI) (*continued*)

Supplementary modules used to expand each CFI subtopic are noted in parentheses.

GUIDE TO INTERVIEWER

INSTRUCTIONS TO THE INTERVIEWER ARE *ITALICIZED*.

CLINICIAN-PATIENT RELATIONSHIP

(Clinician-Patient Relationship, Older Adults)

Elicit possible concerns about the clinic or the clinician-patient relationship, including perceived racism, language barriers, or cultural differences that may undermine goodwill, communication, or care delivery.

Probe details as needed (e.g., "In what way?").

Address possible barriers to care or concerns about the clinic and the clinician-patient relationship raised previously.

Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations.

16. Have you been concerned about this and is there anything that we can do to provide you with the care you need?

Cultural Formulation Interview (CFI)—Informant Version

The CFI—Informant Version collects collateral information from an informant who is knowledgeable about the clinical problems and life circumstances of the identified individual. This version can be used to supplement information obtained from the core CFI or can be used instead of the core CFI when the individual is unable to provide information—as might occur, for example, with children or adolescents, floridly psychotic individuals, or persons with cognitive impairment.

Cultural Formulation Interview (CFI)—Informant Version

GUIDE TO INTERVIEWER	INSTRUCTIONS TO THE INTERVIEWER ARE <i>ITALICIZED</i> .
<i>The following questions aim to clarify key aspects of the presenting clinical problem from the informant's point of view. This includes the problem's meaning, potential sources of help, and expectations for services.</i>	<i>INTRODUCTION FOR THE INFORMANT:</i> I would like to understand the problems that bring your family member/friend here so that I can help you and him/her more effectively. I want to know about <i>your</i> experience and ideas. I will ask some questions about what is going on and how you and your family member/friend are dealing with it. There are no right or wrong answers.
<i>Clarify the informant's relationship with the individual and/or the individual's family.</i>	RELATIONSHIP WITH THE PATIENT 1. How would you describe your relationship to [INDIVIDUAL OR TO FAMILY]? <i>PROBE IF NOT CLEAR:</i> How often do you see [INDIVIDUAL]?

Cultural Formulation Interview (CFI)—Informant
Version (*continued*)

GUIDE TO INTERVIEWER	INSTRUCTIONS TO THE INTERVIEWER ARE <i>ITALICIZED</i>.
-----------------------------	---

CULTURAL DEFINITION OF THE PROBLEM

- | | |
|---|--|
| <p><i>Elicit the informant's view of core problems and key concerns.</i></p> <p><i>Focus on the informant's way of understanding the individual's problem.</i></p> <p><i>Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (e.g., "her conflict with her son").</i></p> | <p>2. What brings your family member/friend here today?</p> <p><i>IF INFORMANT GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE:</i></p> <p>People often understand problems in their own way, which may be similar or different from how doctors describe the problem. How would <i>you</i> describe [INDIVIDUAL'S] problem?</p> |
| <p><i>Ask how informant frames the problem for members of the social network.</i></p> | <p>3. Sometimes people have different ways of describing the problem to family, friends, or others in their community. How would <i>you</i> describe [INDIVIDUAL'S] problem to them?</p> |
| <p><i>Focus on the aspects of the problem that matter most to the informant.</i></p> | <p>4. What troubles you most about [INDIVIDUAL'S] problem?</p> |

Cultural Formulation Interview (CFI)—Informant Version (*continued*)

GUIDE TO INTERVIEWER	INSTRUCTIONS TO THE INTERVIEWER ARE <i>ITALICIZED</i>.
-----------------------------	---

CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT

CAUSES

- | | |
|--|--|
| <p><i>This question indicates the meaning of the condition for the informant, which may be relevant for clinical care.</i></p> <p><i>Note that informants may identify multiple causes depending on the facet of the problem they are considering.</i></p> | <p>5. Why do you think this is happening to [INDIVIDUAL]? What do you think are the causes of his/her [PROBLEM]?
<i>PROMPT FURTHER IF REQUIRED:</i>
Some people may explain the problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes.</p> |
| <p><i>Focus on the views of members of the individual's social network. These may be diverse and vary from the informant's.</i></p> | <p>6. What do others in [INDIVIDUAL'S] family, his/her friends, or others in the community think is causing [INDIVIDUAL'S] [PROBLEM]?</p> |

STRESSORS AND SUPPORTS

- | | |
|---|---|
| <p><i>Elicit information on the individual's life context, focusing on resources, social supports, and resilience. May also probe other supports (e.g., from co-workers, from participation in religion or spirituality).</i></p> | <p>7. Are there any kinds of supports that make his/her [PROBLEM] better, such as from family, friends, or others?</p> |
| <p><i>Focus on stressful aspects of the individual's environment. Can also probe, e.g., relationship problems, difficulties at work or school, or discrimination.</i></p> | <p>8. Are there any kinds of stresses that make his/her [PROBLEM] worse, such as difficulties with money, or family problems?</p> |

Cultural Formulation Interview (CFI)—Informant
Version (*continued*)

GUIDE TO INTERVIEWER	INSTRUCTIONS TO THE INTERVIEWER ARE <i>ITALICIZED</i> .
ROLE OF CULTURAL IDENTITY	
<p><i>Ask the informant to reflect on the most salient elements of the individual's cultural identity. Use this information to tailor questions 10–11 as needed.</i></p>	<p>Sometimes, aspects of people's background or identity can make the [PROBLEM] better or worse. By <i>background</i> or <i>identity</i>, I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, and your faith or religion.</p>
<p><i>Elicit aspects of identity that make the problem better or worse.</i></p>	<p>9. For you, what are the most important aspects of [INDIVIDUAL'S] background or identity?</p>
<p><i>Probe as needed (e.g., clinical worsening as a result of discrimination due to migration status, race/ethnicity, or sexual orientation).</i></p>	<p>10. Are there any aspects of [INDIVIDUAL'S] background or identity that make a difference to his/her [PROBLEM]?</p>
<p><i>Probe as needed (e.g., migration-related problems; conflict across generations or due to gender roles).</i></p>	<p>11. Are there any aspects of [INDIVIDUAL'S] background or identity that are causing other concerns or difficulties for him/her?</p>

Cultural Formulation Interview (CFI)—Informant
Version (*continued*)

GUIDE TO INTERVIEWER	INSTRUCTIONS TO THE INTERVIEWER ARE <i>ITALICIZED</i> .
----------------------	---

CULTURAL FACTORS AFFECTING SELF-COPING AND PAST
HELP SEEKING

SELF-COPING

Clarify individual's self-coping for the problem.

12. Sometimes people have various ways of dealing with problems like [PROBLEM]. What has [INDIVIDUAL] done on his/her own to cope with his/her [PROBLEM]?

PAST HELP SEEKING

Elicit various sources of help (e.g., medical care, mental health treatment, support groups, work-based counseling, folk healing, religious or spiritual counseling, other alternative healing).

Probe as needed (e.g., "What other sources of help has he/she used?").

Clarify the individual's experience and regard for previous help.

13. Often, people also look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing has [INDIVIDUAL] sought for his/her [PROBLEM]?

PROBE IF DOES NOT DESCRIBE USEFULNESS OF HELP RECEIVED:

What types of help or treatment were most useful? Not useful?

BARRIERS

Clarify the role of social barriers to help-seeking, access to care, and problems engaging in previous treatment.

Probe details as needed (e.g., "What got in the way?").

14. Has anything prevented [INDIVIDUAL] from getting the help he/she needs?

PROBE AS NEEDED:

For example, money, work or family commitments, stigma or discrimination, or lack of services that understand his/her language or background?

Cultural Formulation Interview (CFI)—Informant
Version (*continued*)

GUIDE TO INTERVIEWER

INSTRUCTIONS TO THE INTERVIEWER ARE *ITALICIZED*.

CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING

PREFERENCES

Clarify individual's current perceived needs and expectations of help, broadly defined, from the point of view of the informant.

Probe if informant lists only one source of help (e.g., "What other kinds of help would be useful to [INDIVIDUAL] at this time?").

Focus on the views of the social network regarding help seeking.

Now let's talk about the help [INDIVIDUAL] needs.

15. What kinds of help would be most useful to him/her at this time for his/her [PROBLEM]?

16. Are there other kinds of help that [INDIVIDUAL'S] family, friends, or other people have suggested would be helpful for him/her now?

CLINICIAN-PATIENT RELATIONSHIP

Elicit possible concerns about the clinic or the clinician-patient relationship, including perceived racism, language barriers, or cultural differences that may undermine goodwill, communication, or care delivery.

Probe details as needed (e.g., "In what way?").

Address possible barriers to care or concerns about the clinic and the clinician-patient relationship raised previously.

Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations.

17. Have you been concerned about this, and is there anything that we can do to provide [INDIVIDUAL] with the care he/she needs?

Supplementary Modules to the Core Cultural Formulation Interview (CFI)

Guidelines for Implementing the CFI Supplementary Modules

These modules supplement the core Cultural Formulation Interview and can help clinicians conduct a more comprehensive cultural assessment. The first eight supplementary modules explore the domains of the core CFI in greater depth. The next three modules focus on populations with specific needs, such as children and adolescents, older adults, and immigrants and refugees. The last module explores the experiences and views of individuals who perform caregiving functions, in order to clarify the nature and cultural context of caregiving and how they affect social support in the immediate environment of the individual receiving care. In addition to these supplementary modules, an Informant version of the core CFI collects collateral information on the CFI domains from family members or caregivers.

Clinicians may use these supplementary modules in two ways:

- As adjuncts to the core CFI for additional information about various aspects of illness affecting diverse populations. The core CFI refers to pertinent modules under each subheading to facilitate such use of the modules.
- As tools for in-depth cultural assessment independent of the core CFI. Clinicians may administer one, several, or all modules depending on what areas of an individual's problems they would like to elaborate.

Clinicians should note that a few questions in the modules duplicate questions in the core CFI (indicated by an asterisk [*]) or in other modules. This makes it possible to administer each module independently. Clinicians who use the modules as an adjunct to the core CFI or who administer the modules independently may skip redundant questions.

As with the core CFI, follow-up questions may be needed to clarify the individual's answers. Questions may be rephrased as needed. The modules are intended as a guide to cultural assessment and should be used flexibly to maintain a natural flow of the interview and rapport with the individual. In situations where the individual cannot answer these questions (e.g., due to cognitive impairment or severe psychosis) these questions can be administered to the identified caregiver. The caregiver's own perspective can also be ascertained using the module for caregivers.

In every module, instructions to the interviewer are in italics. The modules may be administered during the initial clinical evaluation, at a later point in care, or several times over the course of treatment. Multiple administrations may reveal additional information as rapport develops, especially when assessing the patient-clinician relationship.

Please refer to DSM-5 Section III, chapter “Cultural Formulation,” section “Outline for Cultural Formulation,” for additional suggestions regarding this type of interview.

1. Explanatory Model

Related Core CFI Questions: 1, 2, 3, 4, 5 Some of the core CFI questions are repeated below and are marked with an asterisk (*). The CFI question that is repeated is indicated in brackets.

***GUIDE TO INTERVIEWER:** This module aims to clarify the individual's understanding of the problem based on his or her ideas about cause and mechanism (explanatory models) and past experiences of, or knowing someone with, a similar problem (illness prototypes). The individual may identify the problem as a symptom, a specific term or expression (e.g., “nerves,” “being on edge”), a situation (e.g., loss of a job), or a relationship (e.g., conflict with others). In the examples below, the individual's own words should be used to replace “[PROBLEM]”. If there are multiple problems, each relevant problem can be explored. The following questions may be used to elicit the individual's understanding and experience of that problem or predicament.*

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: I would like to understand the problems that bring you here so that I can help you more effectively. I will be asking you some questions to learn more about your own ideas about the causes of your problems and the way they affect your daily life.

General understanding of the problem

1. *Can you tell me more about how you understand your [PROBLEM]?
[RELATED TO CFI Q#1–2.]
2. What did you know about your [PROBLEM] before it affected you?

Illness prototypes

3. Had you ever had anything like your [PROBLEM] before? Please tell me about that.
4. Do you know anyone else, or heard of anyone else, with this [PROBLEM]? If so, please describe that person's [PROBLEM] and how it affected that person. Do you think this will happen to you too?
5. Have you seen on television, heard on the radio, read in a magazine, or found on the internet anything about your [PROBLEM]? Please tell me about it.

Causal explanations

6. *Can you tell me what you think caused your [PROBLEM]? (*PROBE AS NEEDED*: Is there more than one cause that may explain it?) [RELATED TO CFI Q#4.]
7. Have your ideas about the cause of the [PROBLEM] changed? How? What changed your ideas about the cause?
8. *What do people in your family, friends, or others in your community think caused the [PROBLEM]? (*PROBE AS NEEDED*: Are their ideas about it different from yours? How so?) [RELATED TO CFI Q#5.]
9. How do you think your [PROBLEM] affects your body? Your mind? Your spiritual wellbeing?

Course of illness

10. What usually happens to people who have this [PROBLEM]? In your own case, what do you think is likely to happen?
11. Do you consider your [PROBLEM] to be serious? Why? What is the worst that could happen?
12. How concerned are other people in your family, friends or community about your having this [PROBLEM]? Please tell me about that.

Help seeking and treatment expectations

13. What do you think is the best way to deal with this kind of problem?
14. What do your family, friends, or others in your community think is the best way of dealing with this kind of problem?

2. Level of Functioning

Related Core CFI Question: 3

***GUIDE TO INTERVIEWER:** The following questions aim to clarify the individual's level of functioning in relation to his or her own priorities and those of the cultural reference group. The interview begins with a general question about everyday activities that are important for the individual. Questions follow about domains important for positive health (social relations, work/school, economic viability, and resilience). Questions should be kept relatively broad and open to elicit the individual's own priorities and perspective. For a more detailed evaluation of specific domains of functioning, a standard instrument such as the WHO-DAS II may be used together with this interview.*

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: I would like to know about the daily activities that are most important to you. I would like to better understand how your [PROBLEM] has affected your ability to perform these activities, and how your family and other people around you have reacted to this.

1. How has your [PROBLEM] affected your ability to do the things you need to do each day, that is, your daily activities and responsibilities?
2. How has your [PROBLEM] affected your ability to interact with your family and other people in your life?
3. How has your [PROBLEM] affected your ability to work?
4. How has your [PROBLEM] affected your financial situation?
5. How has your [PROBLEM] affected your ability to take part in community and social activities?
6. How has your [PROBLEM] affected your ability to enjoy everyday life?
7. Which of these concerns are most troubling to you?
8. Which of these concerns are most troubling to your family and to other people in your life?

3. Social Network

Related Core CFI Questions: 5, 6, 12, 15

GUIDE TO INTERVIEWER: *The following questions identify the influences of the informal social network on the individual's problem. Informal social network refers to family, friends and other social contacts through work, places of prayer/worship or other activities and affiliations. Question #1 identifies important people in the individual's social network, and the clinician should tailor subsequent questions accordingly. These questions aim to elicit the social network's response, the individual's interpretation of how this would impact on the problem, and the individual's preferences for involving members of the social network in care.*

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: I would like to know more about how your family, friends, colleagues, co-workers, and other important people in your life have had an impact on your [PROBLEM].

Composition of the individual's social network

1. Who are the most important people in your life at present?
2. Is there anyone in particular whom you trust and can talk with about your [PROBLEM]? Who? Anyone else?

Social network understanding of problem

3. Which of your family members, friends, or other important people in your life know about your [PROBLEM]?
4. What ideas do your family and friends have about the nature of your [PROBLEM]? How do they understand your [PROBLEM]?
5. Are there people who do not know about your [PROBLEM]? Why do they not know about your [PROBLEM]?

Social network response to problem

6. What advice have family members and friends given you about your [PROBLEM]?

7. Do your family, friends, and other people in your life treat you differently because of your [PROBLEM]? How do they treat you differently? Why do they treat you differently?
8. (IF HAS NOT TOLD FAMILY OR FRIENDS ABOUT PROBLEM): Can you tell me more about why you have chosen not to tell family or friends about the [PROBLEM]? How do you think they would respond if they knew about your [PROBLEM]?

Social network as a stress/buffer

9. What have your family, friends, and other people in your life done to make your [PROBLEM] better or easier for you to deal with? (*IF UNCLEAR: How has that made your [PROBLEM] better?*)
10. What kinds of help or support were you expecting from family or friends?
11. What have your family, friends, and other people in your life done to make your [PROBLEM] worse or harder for you to deal with? (*IF UNCLEAR: How has that made your [PROBLEM] worse?*)

Social network in treatment

12. Have any family members or friends helped you get treatment for your [PROBLEM]?
13. What would your family and friends think about your coming here to receive treatment?
14. Would you like your family, friends, or others to be part of your treatment? If so, who would you like to be involved and how?
15. How would involving family or friends make a difference in your treatment?

4. Psychosocial Stressors

Related Core CFI Questions: 7, 9, 10, 12

GUIDE TO INTERVIEWER: The aim of these questions is to further clarify the stressors that have aggravated the problem or otherwise affected the health of the

individual. (Stressors that initially caused the problem are covered in the module on Explanatory Models.) In the examples below, the individual's own words should be used to replace "[STRESSORS]". If there are multiple stressors, each relevant stressor can be explored.

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: You have told me about some things that make your [PROBLEM] worse. I would like to learn more about that.

1. Are there things going on that have made your [PROBLEM] worse, for example, difficulties with family, work, money, or something else? Tell me more about that.
2. How are the people around you affected by these [STRESSORS]?
3. How do you cope with these [STRESSORS]?
4. What have other people suggested about coping with these [STRESSORS]?
5. What else could be done about these [STRESSORS]?

GUIDE TO INTERVIEWER: *Patients may be reluctant to discuss areas of their life they consider sensitive, which may vary across cultural groups. Asking specific questions may help the patient discuss these stressors. Insert questions about relevant stressors here. For example:*

7. Have you experienced discrimination or been treated badly as a result of your background or identity? By background or identity I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your racial or ethnic background, your gender or sexual orientation, and your faith or religion. Have these experiences had an impact on [STRESSORS] or your [PROBLEM]?

5. Spirituality, Religion, and Moral Traditions

Related Core CFI Questions: 6, 7, 8, 9, 10, 11, 12, 14, 15

GUIDE TO INTERVIEWER: *The following questions aim to clarify the influence of spirituality, religion, and other moral or philosophical traditions on the individual's problems and related stresses. People may have multiple spiritual, moral, and religious affiliations or practices. If the individual reports having specific beliefs or practices, inquire about the level of involvement in that tradition and its impact on coping with the clinical problem. In the examples below, the in-*

dividual's own words should be used to replace "[NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)]". If the individual identifies more than one tradition, each can be explored. If the individual does not describe a specific tradition, use the phrase "spirituality, religion or other moral traditions" instead of the specific name of a tradition (e.g., Q5: "What role do spirituality, religion or other moral traditions play in your everyday life?")

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: To help you more effectively, I would like to ask you some questions about the role that spirituality, religion or other moral traditions play in your life and how they may have influenced your dealing with the problems that bring you here.

Spiritual, religious, and moral identity

1. Do you identify with any particular spiritual, religious or moral tradition? Can you tell me more about that?
2. Do you belong to a congregation or community associated with that tradition?
3. What are the spiritual, religious or moral tradition backgrounds of your family members?
4. Sometimes people participate in several traditions. Are there any other spiritual, religious or moral traditions that you identify with or take part in?

Role of spirituality, religion, and moral traditions

5. What role does [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] play in your everyday life?
6. What role does [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] play in your family, for example, family celebrations or choices in marriage or schooling?
7. What activities related to [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] do you carry out in the home, for example, prayers, meditation, or special dietary laws? How often do you carry out these activities? How important are these activities in your life?
8. What activities do you engage in outside the home related to [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)], for

example, attending ceremonies or participating in a [CHURCH, TEMPLE OR MOSQUE]? How often do you attend? How important are these activities in your life?

Relationship to the [PROBLEM]

9. How has [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] helped you cope with your [PROBLEM]?
10. Have you talked to a leader, teacher or others in your [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] community, about your [PROBLEM]? How have you found that helpful?
11. Have you found reading or studying [BOOK(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S), (e.g., BIBLE, KORAN)], or listening to programs related to [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] on TV, radio, the Internet or other media [e.g., DVD, tape] to be helpful? In what way?
12. Have you found any practices related to [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)], like prayer, meditation, rituals, or pilgrimages to be helpful to you in dealing with [PROBLEM]? In what way?

Potential stresses or conflicts related to spirituality, religion, and moral traditions

13. Have any issues related to [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] contributed to [PROBLEM]?
14. Have you experienced any personal challenges or distress in relation to your [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] identity or practices?
15. Have you experienced any discrimination due to your [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] identity or practices?
16. Have you been in conflict with others over spiritual, religious or moral issues?

6. Cultural Identity

Related Core CFI Questions: 6, 7, 8, 9, 10 Some of the core CFI questions are repeated below and are marked with an asterisk (*). The CFI question that is repeated is indicated in brackets.

***GUIDE TO INTERVIEWER:** This module aims to further clarify the individual's cultural identity and how this has influenced the individual's health and well being. The following questions explore the individual's cultural identity and how this may have shaped his or her current problem. We use the word **culture** broadly to refer to all the ways the individual understands his or her identity and experience in terms of groups, communities or other collectivities, including national or geographic origin, ethnic community, racialized categories, gender, sexual orientation, social class, religion/spirituality, and language.*

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: Sometimes peoples' background or identity influences their experience of illness and the type of care they receive. In order to better help you, I would like to understand your own background or identity. By background or identity I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your racial or ethnic background, your gender or sexual orientation, and your faith or religion.

National, Ethnic, Racial Background

1. Where were you born?
2. Where were your parents and grandparents born?
3. How would you describe your family's national, ethnic, and/or racial background?
4. In terms of your background, how do you usually describe yourself to people outside your community? Sometimes people describe themselves somewhat differently to members of their own community. How do you describe yourself to them?
5. Which part of your background do you feel closest to? Sometimes this varies, depending on what aspect of your life we are talking about. What about at home? Or at work? Or with friends?

6. Do you experience any difficulties related to your background, such as discrimination, stereotyping, or being misunderstood?
7. *Is there anything about your background that might impact on your [PROBLEM] or impact on your health or health care more generally? [RELATED TO CFI Q#9.]

Language

8. What languages do you speak fluently?
9. What languages did you speak growing up?
10. What languages are spoken at home? Which of these do you speak?
11. What languages do you use at work or school?
12. What language would you prefer to use in getting health care?
13. What languages do you read? Write?

Migration

GUIDE TO INTERVIEWER: *If the individual was born in another country, ask questions 1–7. [For refugees, refer to the module on Immigrants and Refugees to obtain more detailed migration history.]*

14. When did you come to this country?
15. What made you decide to leave your country of origin?
16. How has your life changed since coming here?
17. What do you miss about the place or community you came from?
18. What are your concerns for your own and your family's future here?
19. What is your current status in this country (e.g., refugee claimant, citizen, student visa, work permit)? *Be aware this may be a sensitive or confidential issue for the individual, if they have precarious status.*
20. How has migration influenced your health or that of your family?
21. Is there anything about your migration experience or current status in this country that has made a difference to your [PROBLEM]?
22. Is there anything about your migration experience or current status that might influence your ability to get the right kind of help for your [PROBLEM]?

Spirituality, Religion, and Moral Traditions

23. Do you identify with any particular religious, moral or spiritual tradition?

GUIDE TO INTERVIEWER: *In the next question, the individual's own words should be used to replace "[NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)]".*

24. What role does [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] play in your everyday life?
25. Do your family members share your spiritual, religious or moral traditions? Can you tell me more about that?

Gender Identity

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: Some individuals feel that their gender [e.g., the social roles and expectations they have related to being male, female, transgender, genderqueer, or intersex] influences their health and the kind of health care they need.

GUIDE TO INTERVIEWER: *In the examples below, the individual's own words should be used to replace "[GENDER]". The interviewer may need to exemplify or explain the term 'GENDER' with relevant wording (e.g., "being a man," "being a transgender woman").*

26. Do you feel that your [GENDER] has influenced your [PROBLEM] or your health more generally?
27. Do you feel that your [GENDER] has influenced your ability to get the kind of health care you need?
28. Do you feel that health care providers have certain assumptions or attitudes about you or your [PROBLEM] because of your [GENDER]?

Sexual Orientation Identity

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: Sexual orientation may also be important to individuals and their comfort in seeking health care. I would like to ask you some questions about

your sexual orientation. Are you comfortable answering questions about your sexual orientation?

29. How would you describe your sexual orientation (e.g., heterosexual, gay, lesbian, bisexual, queer, pansexual, asexual)?
30. Do you feel that your sexual orientation has influenced your [PROBLEM] or your health more generally?
31. Do you feel that your sexual orientation influences your ability to get the kind of health care you need for your [PROBLEM]?
32. Do you feel that health care providers have assumptions or attitudes about you or your [PROBLEM] that are related to your sexual orientation?

Summary

33. You have told me about different aspects of your background and identity and how this has influenced your health and well being. Are there other aspects of your identity I should know about to better understand your health care needs?
34. What are the most important aspects of your background or identity in relation to [PROBLEM]?

7. Coping and Help-Seeking

Related Core CFI Questions: 6, 11, 12, 14, 15 Some of the core CFI question are repeated below and are marked with an asterisk (*). The CFI question that is repeated is indicated in brackets.

GUIDE TO INTERVIEWER: *This module aims to clarify the individual's ways of coping with the current problem. The individual may have identified the problem as a symptom or mentioned a term or expression (e.g., "nerves," "being on edge," spirit possession), or a situation (e.g., loss of a job), or a relationship (e.g., conflict with others). In the examples below, the individual's own words should be used to replace "[PROBLEM]". If there are multiple problems, each relevant problem can be explored. The following questions may be used to learn more about the individual's understanding and experiencing of that problem.*

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: I would like to understand the problems that bring you here so that I can help you more effectively. I will be asking you questions about how you have tried to cope with your problems and get help for them.

Self-coping

1. *Can you tell me more about how you are trying to cope with [PROBLEM] at this time? Has that way of coping with it been helpful? If so, how? [RELATED TO CFI Q#11.]
2. *Can you tell me more about how you tried to cope with the [PROBLEM] or with similar problems in the past? Was that way of coping with it helpful? If so, how? [RELATED TO CFI Q#11.]
3. Have you sought help for your [PROBLEM] on the internet, by reading books, by viewing television shows, or by listening to audiotapes, videos or other sources? If so, which of these? What did you learn? Was it helpful?
4. Do you engage by yourself in practices related to a spiritual, religious or moral tradition to help you cope with your [PROBLEM]? For example, prayer, meditation, or other practices that you carry out by yourself?
5. Have you sought help for your [PROBLEM] from natural remedies or medications that you take without a doctor's prescription, such as over-the-counter medicines? If so, which natural remedies or medications? Were they helpful?

Social network

6. *Have you told a family member about your [PROBLEM]? Have family members helped you cope with the [PROBLEM]? If so, how? What did they suggest you do to cope with the [PROBLEM]? Was it helpful? [RELATED TO CFI Q#15.]
7. *Have you told a friend or co-worker about your [PROBLEM]? Have friends or co-workers helped you cope with the [PROBLEM]? If so, how? What did they suggest you do to cope with the [PROBLEM]? Was it helpful? [RELATED TO CFI Q#15.]

Help- and treatment-seeking beyond social network

8. Are you involved in activities that involve other people related to a spiritual, religious or moral tradition? For example, do you go to worship or religious gatherings, speak with other people in your religious group or speak with the religious or spiritual leader? Have any of these been helpful in coping with [PROBLEM]? In what way?
9. Have you ever tried to get help for your [PROBLEM] from your general doctor? If so, who and when? What treatment did they give? Was it helpful?
10. Have you ever tried to get help for your [PROBLEM] from a mental health clinician, such as a counselor, psychologist, social worker, psychiatrist, or other professional? If so, who and when? What treatment did they give? Was it helpful?
11. Have you sought help from any other kind of helper to cope with your [PROBLEM] other than going to the doctor, for example, a chiropractor, acupuncturist, homeopath, or other kind of healer? What kind of treatment did they recommend to resolve the problem? Was it helpful?

Current treatment episode

12. What were the circumstances that led to your coming here for treatment for your [PROBLEM]? Did anyone suggest you come here for treatment? If so, who, and why did he or she suggest you come here?
13. What help are you hoping to get here [at this clinic] for your [PROBLEM]?

8. Patient-Clinician Relationship

Related Core CFI Question: 16 Some of the core CFI questions are repeated below and are marked with an asterisk (*). The CFI question that is repeated is indicated in brackets.

GUIDE TO INTERVIEWER: *The following questions address the role of culture in the patient-clinician relationship with respect to the individual's presenting concerns and to the clinician's evaluation of the individual's problem. We use the word **culture** broadly to refer to all the ways the individual understands his or her identity and experience in terms of groups, communities or other collectiv-*

ities, including national or geographic origin, ethnic community, racialized categories, gender, sexual orientation, social class, religion/spirituality, and language.

The first set of questions evaluates four domains in the clinician-patient relationship from the point of view of the patient: experiences, expectations, communication, and possibility of collaboration with the clinician. The second set of questions is directed to the clinician to guide reflection on the role of cultural factors in the clinical relationship, the assessment, and treatment planning.

INTRODUCTION FOR THE PATIENT: I would like to learn about how it has been for you to talk with me and other clinicians about your [PROBLEM] and your health more generally. I will ask some questions about your views, concerns, and expectations.

QUESTIONS FOR THE PATIENT:

1. What kind of experiences have you had with clinicians in the past? What was most helpful to you?
2. Have you had difficulties with clinicians in the past? What did you find difficult or unhelpful?
3. Now let's talk about the help that you would like to get here. Some people prefer clinicians of a similar background (for example, age, race, religion, or some other characteristic) because they think it may be easier to understand each other. Do you have any preference or ideas about what kind of clinician might understand you best?
4. *Sometimes differences among patients and clinicians make it difficult for them to understand each other. Do you have any concerns about this? If so, in what way? [RELATED TO CFI Q#16.]

GUIDE TO INTERVIEWER: *Question #5 addresses the patient-clinician relationship moving forward in treatment. It elicits the patient's expectations of the clinician and may be used to start a discussion on how the two of them can collaborate in the individual's care.*

5. What patients expect from their clinicians is important. As we move forward in your care, how can we best work together?

QUESTIONS FOR THE CLINICIAN AFTER THE INTERVIEW:

1. How did you feel about your relationship with the patient? Did cultural similarities and differences influence your relationship? In what way?
2. What was the quality of communication with the patient? Did cultural similarities and differences influence your communication? In what way?
3. If you used an interpreter, how did the presence of an interpreter or his/her way of interpreting influence your relationship or your communication with the patient and the information you received?
4. How do the patient's cultural background or identity, life situation, and/or social context influence your understanding of his/her problem and your diagnostic assessment?
5. How do the patient's cultural background or identity, life situation, and/or social context influence your treatment plan or recommendations?
6. Did the clinical encounter confirm or call into question any of your prior ideas about the cultural background or identity of the patient? If so, in what way?
7. Are there aspects of your own identity that may influence your attitudes toward this patient?

9. School-Age Children and Adolescents

Related Core CFI Questions: 8, 9, 10

GUIDE TO INTERVIEWER: *This supplement is directed to adolescents and mature school-age children. It should be used in conjunction with standard child mental health assessments that evaluate family relations (including intergenerational issues), peer relations, and the school environment. The aim of these questions is to identify, from the perspective of the child/youth, the role of age-related cultural expectations, the possible cultural divergences between school, home, and the peer group, and whether these issues impact on the situation or problem that brought the youth for care. The questions indirectly explore cultural challenges, stressors and resilience, and issues of cultural hybridity, mixed ethnicity or multiple ethnic identifications. Peer group belonging is important to children and adolescents, and questions exploring ethnicity, religious identity, racism or gender difference should be included following the child's lead. Some children may not be able to answer all questions; clinicians should select and adapt questions to ensure they are developmentally appropriate for the individual. Children should not be used as informants*

to provide socio-demographic information on the family or an explicit analysis of the cultural dimensions of their problems. An Addendum lists cultural aspects of development and parenting that can be evaluated during parents' interviews.

INTRODUCTION FOR THE CHILD/YOUTH: We have talked about the concerns of your family. Now I would like to know more about how you feel about being ____ years old.

Feelings of age appropriateness in different settings

1. Do you feel you are like other children/youth your age? In what way?
2. Do you sometimes feel different from other children/youth your age? In what way?
3. **IF THE CHILD/YOUTH ACKNOWLEDGES SOMETIMES FEELING DIFFERENT:** Does this feeling of being different happen more at home, at school, at work, and/or some other place?
4. Do you feel your family is different from other families?
5. Do you use different languages? With whom and when?
6. Does your name have any special meaning for you? Your family? Your community?
7. Is there something special about you that you like or that you are proud of?

Age-related stressors and supports

8. What do you like about being a child/youth at home? At school? With friends?
9. What don't you like about being a child/youth at home? At school? With friends?
10. Who is there to support you when you feel you need it? At home? At school? Among your friends?

Age-related expectations

GUIDE TO INTERVIEWER: *Concepts of childhood and age-appropriate behavior vary significantly across cultures. The aim of these questions is to elicit the normative frame(s) of the child/family and how this may be different from other cultural environments.*

11. What do your parents or grandparents expect from a child/youth your age? (*CLARIFY*: For example, chores, schoolwork, play, religious observance.)
12. What do your school teachers expect from a child/youth your age?
13. *IF INDIVIDUAL HAS SIBLINGS*: What do your siblings expect from a child/youth your age? (*CLARIFY*: For example, babysitting, help with homework, dating, dress.)
14. What do other children/youth your age expect from a child/youth your age?

Transition to adulthood/maturity (FOR ADOLESCENTS ONLY)

15. Are there any important celebrations or events in your community to recognize reaching a certain age or growing up?
16. When is a youth considered ready to become an adult in your family or community?
17. When is a youth considered ready to become an adult according to your school teachers?
18. What is good or difficult about becoming a young woman or a young man in your family? In your school? In your community?
19. How do you feel about “growing up” or becoming an adult?
20. In what ways are your life and responsibilities different from the life and responsibilities of your parents?

ADDENDUM FOR PARENTS' INTERVIEW

GUIDE TO INTERVIEWER: Information on cultural influences on development and parenting is best obtained by interviewing the child's parents or caretakers. In addition to issues directly related to presenting problems, it is useful to inquire about:

- The child's particular place in the family (e.g., oldest boy, only girl)
- The process of naming the child (Who chose the name? Does it have special meaning? Who else is called like this?)

- Developmental milestones in the culture of origin of the mother (and father): expected age for weaning, walking, toilet training, speaking. Vision of normal autonomy/dependency, appropriate disciplining and so on
- Perceptions of age-appropriate behaviors (e.g., age for staying home alone, participation in chores, religious observance, play)
- Child-adult relations (e.g., expression of respect, eye contact, physical contact)
- Gender relations (expectations around appropriate girl-boy behavior, dress code)
- Languages spoken at home, in daycare, at school
- The importance of religion, spirituality, and community in family life and related expectations for the child.

10. Older Adults

Related Core CFI Questions: 5, 6, 7, 8, 9, 10, 12, 13, 15, 16

GUIDE TO INTERVIEWER: *The following questions are directed to older adults. The goal of these questions is to identify the role of cultural conceptions of aging and age-related transitions on the illness episode.*

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: I would like to ask some questions to better understand your problem and how we can help you with it, taking into account your age and specific experiences.

Conceptions of aging and cultural identity

1. How would you describe a person of your age?
2. How does your experience of aging compare to that of your friends and relatives who are of a similar age?
3. Is there anything about being your age that helps you cope with your current life situation?

Conceptions of aging in relationship to illness attributions and coping

4. How does being older influence your [PROBLEM]? Would it have affected you differently when you were younger?

5. Are there ways that being older influences how you deal with your [PROBLEM]? Would you have dealt with it differently when you were younger?

Influence of comorbid medical problems and treatments on illness

6. Have you had health problems due to your age?
7. How have your health conditions or the treatments for your health conditions affected your [PROBLEM]?
8. Are there any ways that your health conditions or treatments influence how you deal with your [PROBLEM]?
9. Are there things that are important to you that you are unable to do because of your health or age?

Quality and nature of social supports and caregiving

10. Who do you rely on for help or support in your daily life in general? Has this changed now that you are going through [PROBLEM]?
11. How has [PROBLEM] affected your relationships with family and friends?
12. Are you receiving the amount and kind of support you expected?
13. Do the people you rely on share your view of your [PROBLEM]?

Additional age-related transitions

14. Are there other changes you are going through related to aging that are important for us to know about in order to help you with your [PROBLEM]?

Positive and negative attitudes towards aging and clinician–patient relationship

15. How has your age affected how health providers treat you?
16. Have any people, including health care providers, discriminated against you or treated you poorly because of your age? Can you tell me more about that? How has this experience affected your [PROBLEM] or how you deal with it?

17. *[IF THERE IS A SIGNIFICANT AGE DIFFERENCE BETWEEN PROVIDER AND PATIENT:]* Do you think that the difference in our ages will influence our work in any way? If so, how?

11. Immigrants and Refugees

Related Core CFI Questions: 7, 8, 9, 10, 13

GUIDE TO INTERVIEWER: *The following questions aim to collect information from refugees and immigrants about their experiences of migration and resettlement. Many refugees have experienced stressful interviews with officials or health professionals in their home country, during the migration process (which may involve prolonged stays in refugee camps or other precarious situations), and in the receiving country, so it may take longer than usual for the interviewee to feel comfortable with and trust the interview process. When patient and clinician do not share a high level of fluency in a common language, accurate language translation is essential.*

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: Leaving one's country of origin and resettling elsewhere can have a great impact on people's lives and health. To better understand your situation, I would like to ask you some questions related to your journey here from your country of origin.

Background information

1. What is your country of origin?
2. How long have you been living here in _____ (HOST COUNTRY)?
3. When and with whom did you leave _____ (COUNTRY OF ORIGIN)?
4. Why did you leave _____ (COUNTRY OF ORIGIN)?

Pre-migration difficulties

5. Prior to arriving in _____ (HOST COUNTRY), were there any challenges in your country of origin that you or your family found especially difficult?

6. Some people experience hardship, persecution, or even violence before leaving their country of origin. Has this been the case for you or members of your family? Can you tell me something about your experiences?

Migration-related losses and challenges

7. Of the persons important/close to you, who stayed behind?
8. Often people leaving a country experience losses. Did you or any of your family members experience losses upon leaving the country? If so, what are they?
9. Were there any challenges on your journey to _____ (HOST COUNTRY) that you or your family found especially difficult?
10. Do you or your family miss anything about your way of life in (COUNTRY OF ORIGIN)?

Ongoing relationship with country of origin

11. Do you have concerns about relatives that remain in (COUNTRY OF ORIGIN)?
12. Do relatives in (COUNTRY OF ORIGIN) have any expectations of you?

Resettlement and new life

13. Have you or your family experienced any difficulties related to your visa, citizenship, or refugee status here in _____ (HOST COUNTRY)?
14. Are there any (other) challenges or problems you or others in your family are facing related to your resettlement here?
15. Has coming to [HOST COUNTRY] resulted in something positive for you or your family? Can you tell me more about that?

Relationship with problem

16. Is there anything about your migration experience or current status in this country that has made a difference to your [PROBLEM]?

17. Is there anything about your migration experience or current status that might make it easier or harder to get help for your [PROBLEM]?

Future expectations

18. What hopes and plans do you have for you and your family in the coming years?

12. Caregivers

Related Core CFI Questions: 6, 12, 14

GUIDE TO INTERVIEWER: *This module is designed to be administered to individuals who provide caregiving for the individual being assessed with the CFI. This module aims to explore the nature and cultural context of caregiving, and the social support and stresses in the immediate environment of the individual receiving care, from the perspective of the caregiver.*

INTRODUCTION FOR THE CAREGIVER: People like yourself who take care of the needs of patients are very important participants in the treatment process. I would like to understand your relationship with [INDIVIDUAL RECEIVING CARE] and how you help him/her with his/her problems and concerns. By *help*, I mean support in the home, community, or clinic. Knowing more about that will help us plan his/her care more effectively.

Nature of relationship

1. How long have you been taking care of [INDIVIDUAL RECEIVING CARE]? How did this role for you start?
2. How are you connected to [INDIVIDUAL RECEIVING CARE]?

Caregiving activities and cultural perceptions of caregiving

3. How do you help him/her with the [PROBLEM] or with day-to-day activities?
4. What is most rewarding about helping him/her?
5. What is most challenging about helping him/her?
6. How, if at all, has his/her [PROBLEM] changed your relationship?

Sometimes caregivers like yourself are influenced in doing what they do by cultural traditions of helping others, such as beliefs and practices in your family or community. By cultural traditions I mean, for example, what is done in the communities you belong to, where you or your family are from, or among people who speak your language or who share your race or ethnic background, your gender or sexual orientation, or your faith or religion.

7. Are there any cultural traditions that influence how you approach helping [INDIVIDUAL RECEIVING CARE]?
8. Is the amount or kind of help you are giving him/her different in any way from what would be expected in the community that you come from or the one he/she comes from? Is it different from what society in general would expect?

Social context of caregiving

9. [IF CAREGIVER IS A FAMILY MEMBER:] How do you, as a family, cope with this [PROBLEM]?
10. Are there others, such as family members, friends, or neighbors, who also help him/her with the [PROBLEM]? If so, what do they do?
11. How do you feel about how much or how little others are helping with his/her [PROBLEM]?

Clinical support for caregiving

12. How do you see yourself helping to provide care to [INDIVIDUAL RECEIVING CARE] now and in the future?
13. [IF UNCLEAR:] How do you see yourself helping with the care that he/she receives in this clinic?
14. How can we make it easier for you to be able to help [INDIVIDUAL RECEIVING CARE] with the [PROBLEM]?

This page intentionally left blank

DSM-5 Glossary of Cultural Concepts of Distress

Ataque de nervios

Ataque de nervios (“attack of nerves”) is a syndrome among individuals of Latino descent, characterized by symptoms of intense emotional upset, including acute anxiety, anger, or grief; screaming and shouting uncontrollably; attacks of crying; trembling; heat in the chest rising into the head; and becoming verbally and physically aggressive. Dissociative experiences (e.g., depersonalization, derealization, amnesia), seizure-like or fainting episodes, and suicidal gestures are prominent in some *ataques* but absent in others. A general feature of an *ataque de nervios* is a sense of being out of control. Attacks frequently occur as a direct result of a stressful event relating to the family, such as news of the death of a close relative, conflicts with a spouse or children, or witnessing an accident involving a family member. For a minority of individuals, no particular social event triggers their *ataques*; instead, their vulnerability to losing control comes from the accumulated experience of suffering (Guarnaccia et al. 1993, 1996; Lewis-Fernández et al. 2010).

No one-to-one relationship has been found between *ataque* and any specific psychiatric disorder, although several disorders, including panic disorder, other specified or unspecified dissociative disorder, and conversion disorder, have symptomatic overlap with *ataque* (Brown and Lewis-Fernández 2011; Guarnaccia et al. 1993; Lewis-Fernández et al. 2002a, 2002b).

Reprinted from the *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition, Washington, DC, American Psychiatric Association, 2013. Used with permission. Copyright © 2013 American Psychiatric Association.

In community samples, *ataque* is associated with suicidal ideation, disability, and outpatient psychiatric utilization, after adjustment for psychiatric diagnoses, traumatic exposure, and other covariates (Lewis-Fernández et al. 2009). However, some *ataques* represent normative expressions of acute distress (e.g., at a funeral) without clinical sequelae. The term *ataque de nervios* may also refer to an idiom of distress that includes any “fit”-like paroxysm of emotionality (e.g., hysterical laughing) and may be used to indicate an episode of loss of control in response to an intense stressor.

Related conditions in other cultural contexts: Indisposition in Haiti, blacking out in the Southern United States, and falling out in the West Indies (Weidman 1979).

Related conditions in DSM-5: Panic attack, panic disorder, other specified or unspecified dissociative disorder, conversion (functional neurologic symptom) disorder, intermittent explosive disorder, other specified or unspecified anxiety disorder, other specified or unspecified trauma and stressor-related disorder.

References

- Brown RJ, Lewis-Fernández R: Culture and conversion disorder: implications for DSM-5. *Psychiatry* 74(3):187–206, 2011
- Guarnaccia PJ, Canino G, Rubio-Stipec M, et al: The prevalence of ataques de nervios in the Puerto Rico disaster study: the role of culture in psychiatric epidemiology. *J Nerv Ment Dis* 181(3):157–165, 1993
- Guarnaccia PJ, Rivera M, Franco F, et al: The experiences of ataques de nervios: towards an anthropology of emotions in Puerto Rico. *Cult Med Psychiatry* 20(3):343–367, 1996
- Lewis-Fernández R, Garrido-Castillo P, Bennasar MC, et al: Dissociation, childhood trauma, and ataque de nervios among Puerto Rican psychiatric outpatients. *Am J Psychiatry* 159(9):1603–1605, 2002a
- Lewis-Fernández R, Guarnaccia PJ, Martínez IE, et al: Comparative phenomenology of ataques de nervios, panic attacks, and panic disorder. *Cult Med Psychiatry* 26(2):199–223, 2002b
- Lewis-Fernández R, Horvitz-Lennon M, Blanco C, et al: Significance of endorsement of psychotic symptoms by US Latinos. *J Nerv Ment Dis* 197(5):337–347, 2009
- Lewis-Fernández R, Gorritz M, Raggio GA, et al: Association of trauma-related disorders and dissociation with four idioms of distress among Latino psychiatric outpatients. *Cult Med Psychiatry* 34(2):219–243, 2010

Weidman HH: Falling-out: a diagnostic and treatment problem viewed from a trans-cultural perspective. *Soc Sci Med Med Anthropol* 13B(2):95–112, 1979

Dhat syndrome

Dhat syndrome is a term that was coined in South Asia little more than half a century ago to account for common clinical presentations of young male patients who attributed their various symptoms to semen loss. Despite the name, it is not a discrete syndrome but rather a cultural explanation of distress for patients who refer to diverse symptoms, such as anxiety, fatigue, weakness, weight loss, impotence, other multiple somatic complaints, and depressive mood. The cardinal feature is anxiety and distress about the loss of *dhat* in the absence of any identifiable physiological dysfunction (Gautham et al. 2008). *Dhat* was identified by patients as a white discharge that was noted on defecation or urination (Murthy and Wig 2002). Ideas about this substance are related to the concept of *dhatu* (semen) described in the Hindu system of medicine, Ayurveda, as one of seven essential bodily fluids whose balance is necessary to maintain health (Jadhav 2004; Raguram et al. 1994).

Although *dhat syndrome* was formulated as a cultural guide to local clinical practice, related ideas about the harmful effects of semen loss have been shown to be widespread in the general population (Malhotra and Wig 1975), suggesting a cultural disposition for explaining health problems and symptoms with reference to *dhat syndrome*. Research in health care settings has yielded diverse estimates of the syndrome's prevalence (e.g., 64% of men attending psychiatric clinics in India for sexual complaints; 30% of men attending general medical clinics in Pakistan) (Bhatia and Malik 1991; Mumford 1996). Although *dhat syndrome* is most commonly identified with young men from lower socioeconomic backgrounds, middle-aged men may also be affected (Khan 2005). Comparable concerns about white vaginal discharge (leukorrhea) have been associated with a variant of the concept for women (Trollope-Kumar 2001).

Related conditions in other cultural contexts: *koro* in Southeast Asia, particularly Singapore, and *shen-k'uei* ("kidney deficiency") in China (Sumathipala et al. 2004).

Related conditions in DSM-5: Major depressive disorder, persistent depressive disorder (dysthymia), generalized anxiety disorder, somatic symptom

disorder, illness anxiety disorder, erectile disorder, early (premature) ejaculation, other specified or unspecified sexual dysfunction, academic problem.

References

- Bhatia MS, Malik SC: Dhat syndrome—a useful diagnostic entity in Indian culture. *Br J Psychiatry* 159:691–695, 1991
- Gautham M, Singh R, Weiss H, et al: Socio-cultural, psychosexual and biomedical factors associated with genital symptoms experienced by men in rural India. *Trop Med Int Health* 13(3):384–395, 2008
- Jadhav S: Dhat syndrome: a re-evaluation. *Psychiatry* 3(8):14–16, 2004
- Khan N: Dhat syndrome in relation to demographic characteristics. *Indian J Psychiatry* 47(1):54–57, 2005
- Malhotra HK, Wig NN: Dhat syndrome: a culture-bound sex neurosis of the Orient. *Arch Sex Behav* 4(5):519–528, 1975
- Mumford DB: The ‘Dhat syndrome’: a culturally determined symptom of depression? *Acta Psychiatr Scand* 94(3):163–167, 1996
- Murthy RS, Wig NN: Psychiatric diagnosis and classification in developing countries, in *Psychiatric Diagnosis and Classification*. Edited by Maj M, Gaebel W, López-Ibor JJ, et al. Chichester, UK, Wiley, 2002, pp 249–279
- Raguram R, Jadhav S, Weiss MG: Historical perspectives on Dhat syndrome. *NIMHANS Journal* 12(2):117–124, 1994
- Sumathipala A, Siribaddana SH, Bhugra D: Culture-bound syndromes: the story of dhat syndrome. *Br J Psychiatry* 184:200–209, 2004
- Trollope-Kumar K: Cultural and biomedical meanings of the complaint of leukorrhea in South Asian women. *Trop Med Int Health* 6(4):260–266, 2001

Khyâl cap

“*Khyâl* attacks” (*khyâl cap*), or “wind attacks,” is a syndrome found among Cambodians in the United States and Cambodia (Hinton et al. 2001, 2010, 2012). Common symptoms include those of panic attacks, such as dizziness, palpitations, shortness of breath, and cold extremities, as well as other symptoms of anxiety and autonomic arousal (e.g., tinnitus and neck soreness). *Khyâl* attacks include catastrophic cognitions centered on the concern that *khyâl* (a windlike substance) may rise in the body—along with blood—and cause a range of serious effects (e.g., compressing the lungs to cause shortness of breath and asphyxia; entering the cranium to cause tinnitus, dizziness,

blurry vision, and a fatal syncope). *Khyâl* attacks may occur without warning, but are frequently brought about by triggers such as worrisome thoughts, standing up (i.e., orthostasis), specific odors with negative associations, and agoraphobic-type cues like going to crowded spaces or riding in a car. *Khyâl* attacks usually meet panic attack criteria and may shape the experience of other anxiety and trauma- and stressor-related disorders. *Khyâl* attacks may be associated with considerable disability.

Related conditions in other cultural contexts: Laos (*pen lom*), Tibet (*srog rlung gi nad*), Sri Lanka (*vata*), and Korea (*hwa byung*) (Hinton and Good 2009).

Related conditions in DSM-5: Panic attack, panic disorder, generalized anxiety disorder, agoraphobia, posttraumatic stress disorder, illness anxiety disorder.

References

- Hinton DE, Good BJ (eds): Culture and Panic Disorder. Palo Alto, CA, Stanford University Press, 2009
- Hinton DE, Um K, Ba P: Kyol goeu (“wind overload”), part I: a cultural syndrome of orthostatic panic among Khmer refugees. *Transcult Psychiatry* 38(4):403–432, 2001
- Hinton DE, Pich V, Marques L, et al: Khyâl attacks: a key idiom of distress among traumatized Cambodia refugees. *Cult Med Psychiatry* 34(2):244–278, 2010
- Hinton DE, Hinton AL, Eng KT, et al: PTSD and key somatic complaints and cultural syndromes among rural Cambodians: the results of a needs assessment survey. *Med Anthropol Q* 26(3):383–407, 2012

Kufungisisa

Kufungisisa (“thinking too much” in Shona) is an idiom of distress and a cultural explanation among the Shona of Zimbabwe. As an explanation, it is considered to be causative of anxiety, depression, and somatic problems (e.g., “my heart is painful because I think too much”). As an idiom of psychosocial distress, it is indicative of interpersonal and social difficulties (e.g., marital problems, having no money to take care of children) (Patel et al. 1995a, 1995b). *Kufungisisa* involves ruminating on upsetting thoughts, particularly worries (Abas and Broadhead 1997).

Kufungisisa is associated with a range of psychopathology, including anxiety symptoms, excessive worry, panic attacks, depressive symptoms, and irritability (Patel et al. 1995b). In a study of a random community sample, two-thirds of the cases identified by a general psychopathology measure were of this complaint (Abas and Broadhead 1997).

In many cultures, “thinking too much” is considered to be damaging to the mind and body (Hinton et al. 2012; van der Ham et al. 2011; Yarris 2011) and to cause specific symptoms like headache and dizziness. “Thinking too much” may also be a key component of cultural syndromes such as “brain fog” in Nigeria (Ola and Igbokwe 2011; Ola et al. 2009). In the case of brain fog, “thinking too much” is primarily attributed to excessive study, which is considered to damage the brain in particular, with symptoms including feelings of heat or crawling sensations in the head.

Related conditions in other cultural contexts: “Thinking too much” is a common idiom of distress and cultural explanation across many countries and ethnic groups. It has been described in Africa (Avotri and Walters 1999; Patel et al. 1995a, 1995b), the Caribbean and Latin America (Bolton et al. 2012; Keys et al. 2012; Yarris 2011), and among East Asian (Frye and D’Avanzo 1994; van der Ham et al. 2011; Westermeyer and Wintrob 1979; Yang et al. 2010) and Native American (Kirmayer et al. 1997) groups.

Related conditions in DSM-5: Major depressive disorder, persistent depressive disorder (dysthymia), generalized anxiety disorder, posttraumatic stress disorder, obsessive-compulsive disorder, persistent complex bereavement disorder (see “Conditions for Further Study” [DSM-5 pp. 789–792]).

References

- Abas MA, Broadhead JC: Depression and anxiety among women in an urban setting in Zimbabwe. *Psychol Med* 27(1):59–71, 1997
- Avotri JY, Walters V: “You just look at our work and see if you have any freedom on earth”: Ghanaian women’s accounts of their work and their health. *Soc Sci Med* 48(9):1123–1133, 1999
- Bolton P, Surkan PJ, Gray AE, et al: The mental health and psychosocial effects of organized violence: a qualitative study in northern Haiti. *Transcult Psychiatry* 49(3–4):590–612, 2012
- Frye BA, D’Avanzo C: Themes in managing culturally defined illness in the Cambodian refugee family. *J Community Health Nurs* 11(2):89–98, 1994

- Hinton DE, Hinton AL, Eng KT, et al: PTSD and key somatic complaints and cultural syndromes among rural Cambodians: the results of a needs assessment survey. *Med Anthropol Q* 26:383–407, 2012 10.1111/j.1548-1387.2012.01224.x
- Keys HM, Kaiser BN, Kohrt BA, et al: Idioms of distress, ethnopsychology, and the clinical encounter in Haiti's Central Plateau. *Soc Sci Med* 75(3):555–564, 2012
- Kirmayer LJ, Fletcher CM, Boothroyd LJ: Inuit attitudes toward deviant behavior: a vignette study. *J Nerv Ment Dis* 185(2):78–86, 1997
- Ola BA, Igbokwe DO: Factorial validation and reliability analysis of the Brain Fog Syndrome Scale. *Afr Health Sci* 11(3):334–340, 2011
- Ola BA, Morakinyo O, Adewuya AO: Brain fog syndrome—a myth or a reality. *Afr J Psychiatry (Johannesbg)* 12(2):135–143, 2009
- Patel V, Gwanzura F, Simunyu E, et al: The phenomenology and explanatory models of common mental disorder: a study in primary care in Harare, Zimbabwe. *Psychol Med* 25(6):1191–1199, 1995a
- Patel V, Simunyu E, Gwanzura F: Kufungisisa (thinking too much): a Shona idiom for non-psychotic mental illness. *Cent Afr J Med* 41(7):209–215, 1995b
- van der Ham L, Wright P, Van TV, et al: Perceptions of mental health and help-seeking behavior in an urban community in Vietnam: an explorative study. *Community Ment Health J* 47(5):574–582, 2011
- Westermeyer J, Wintrob R: “Folk” explanations of mental illness in rural Laos. *Am J Psychiatry* 136(7):901–905, 1979
- Yang LH, Phillips MR, Lo G, et al: “Excessive thinking” as explanatory model for schizophrenia: impacts on stigma and “moral” status in Mainland China. *Schizophr Bull* 36(4):836–845, 2010
- Yarris KE: The pain of “thinking too much”: dolor de cerebro and the embodiment of social hardship among Nicaraguan women. *Ethos* 39(2):226–248, 2011 10.1111/j.1548-1352.2011.01186.x

Maladi moun

Maladi moun (literally “humanly caused illness,” also referred to as “sent sickness”) is a cultural explanation in Haitian communities for diverse medical and psychiatric disorders. In this explanatory model, interpersonal envy and malice cause people to harm their enemies by sending illnesses such as psychosis (Brodwin 1996), depression (Nicolas et al. 2007), social or academic failure, and inability to perform activities of daily living (Desrosiers and St. Fleurose 2002). The etiological model assumes that illness may be caused by others’ envy and hatred, provoked by the victim’s economic success as evi-

denced by a new job or expensive purchase (Farmer 1990). One person's gain is assumed to produce another person's loss, so visible success makes one vulnerable to attack (Vonarx 2007). Assigning the label of sent sickness depends on mode of onset and social status more than presenting symptoms. The acute onset of new symptoms or an abrupt behavioral change raises suspicions of a spiritual attack. Someone who is attractive, intelligent, or wealthy is perceived as especially vulnerable, and even young healthy children are at risk (DeSantis and Thomas 1990).

Related conditions in other cultural contexts: Concerns about illness (typically, physical illness) caused by envy or social conflict are common across cultures and often expressed in the form of "evil eye" (e.g., in Spanish, *mal de ojo*, in Italian, *mal'occhiu*) (Al-Sughayir 1996; Migliore and Mal'occhiu 1997; Risser and Mazur 1995).

Related conditions in DSM-5: Delusional disorder, persecutory type; schizophrenia with paranoid features.

References

- Al-Sughayir MA: Public view of the "evil eye" and its role in psychiatry: a study in Saudi society. *Arab Journal of Psychiatry* 7(2):152–160, 1996
- Brodwin P: *Medicine and Morality in Haiti: The Contest for Healing Power* (Cambridge Studies in Medical Anthropology series). Cambridge, UK, Cambridge University Press, 1996
- DeSantis L, Thomas JT: The immigrant Haitian mother: transcultural nursing perspective on preventive health care for children. *J Transcult Nurs* 2(1):2–15, 1990
- Desrosiers A, St. Fleurose S: Treating Haitian patients: key cultural aspects. *Am J Psychother* 56(4):508–521, 2002
- Farmer P: Sending sickness: sorcery, politics, and changing concepts of AIDS in rural Haiti. *Med Anthropol Q* 4(1):6–27, 1990 10.1525/maq.1990.4.1.02a00020
- Migliore S: *Mal'occhiu: Ambiguity, Evil Eye, and the Language of Distress*. Toronto, ON, University of Toronto Press, 1997
- Nicolas G, Desilva AM, Subreboast KL, et al: Expression and treatment of depression among Haitian immigrant women in the United States: clinical observations. *Am J Psychother* 61(1):83–98, 2007
- Risser AL, Mazur LJ: Use of folk remedies in a Hispanic population. *Arch Pediatr Adolesc Med* 149(9):978–981, 1995
- Vonarx N: Vodou, illness and models in Haiti: from local meanings to broader relations of domination. *Anthropology in Action* 14(3):18–29, 2007

Nervios

Nervios (“nerves”) is a common idiom of distress among Latinos in the United States and Latin America. *Nervios* refers to a general state of vulnerability to stressful life experiences and to difficult life circumstances (Baer et al. 2003; Finkler 2001; Guarnaccia and Farias 1988; Guarnaccia et al. 2003; Lewis-Fernández et al. 2010; Low 1981; Weller et al. 2008). The term *nervios* includes a wide range of symptoms of emotional distress, somatic disturbance, and inability to function (Salgado de Snyder et al. 2000). The most common symptoms attributed to *nervios* include headaches and “brain aches” (occipital neck tension), irritability, stomach disturbances, sleep difficulties, nervousness, easy tearfulness, inability to concentrate, trembling, tingling sensations, and *mareos* (dizziness with occasional vertigo-like exacerbations) (Baer et al. 2003; Guarnaccia et al. 2003). *Nervios* is a broad idiom of distress that spans the range of severity from cases with no mental disorder to presentations resembling adjustment, anxiety, depressive, dissociative, somatic symptom, or psychotic disorders. “Being nervous since childhood” appears to be more of a trait and may precede social anxiety disorder, while “being ill with nerves” is more related than other forms of *nervios* to psychiatric problems, especially dissociation (Lewis-Fernández et al. 2010) and depression (Weller et al. 2008).

Related conditions in other cultural contexts: *Nevra* among Greeks in North America (Dunk 1989), *nierbi* among Sicilians in North America (Migliore 2001), and *nerves* among whites in Appalachia (Van Schaik 1989) and Newfoundland (Davis 1989).

Related conditions in DSM-5: Major depressive disorder, persistent depressive disorder (dysthymia), generalized anxiety disorder, social anxiety disorder, other specified or unspecified dissociative disorder, somatic symptom disorder, schizophrenia.

References

- Baer RD, Weller SC, de Alba Garcia JG, et al: A cross-cultural approach to the study of the folk illness *nervios*. *Cult Med Psychiatry* 27(3):315–337, 2003
- Davis DL: The variable character of nerves in a Newfoundland fishing village. *Med Anthropol* 11(1):63–78, 1989
- Dunk P: Greek women and broken nerves in Montreal. *Med Anthropol* 11(1):29–45, 1989

- Finkler K: Physicians at Work, Patients in Pain: Biomedical Practice and Patient Response in Mexico, 2nd Edition. Durham, NC, Carolina Academic Press, 2001
- Guarnaccia PJ, Farias P: The social meanings of nervios: a case study of a Central American woman. *Soc Sci Med* 26(12):1223–1231, 1988
- Guarnaccia PJ, Lewis-Fernández R, Marano MR: Toward a Puerto Rican popular nosology: nervios and ataque de nervios. *Cult Med Psychiatry* 27(3):339–366, 2003
- Lewis-Fernández R, Gorritz M, Raggio GA, et al: Association of trauma-related disorders and dissociation with four idioms of distress among Latino psychiatric outpatients. *Cult Med Psychiatry* 34(2):219–243, 2010
- Low SM: The meaning of nervios: a sociocultural analysis of symptom presentation in San Jose, Costa Rica. *Cult Med Psychiatry* 5(1):25–47, 1981
- Migliore S: From illness narratives to social commentary: a Pirandellian approach to “nerves.” *Med Anthropol Q* 15(1):100–125, 2001
- Salgado de Snyder VN, Diaz-Perez MJ, Ojeda VD: The prevalence of nervios and associated symptomatology among inhabitants of Mexican rural communities. *Cult Med Psychiatry* 24(4):453–470, 2000
- Van Schaik E: Paradigms underlying the study of nerves as a popular illness term in eastern Kentucky. *Med Anthropol* 11(1):15–28, 1989
- Weller SC, Baer RD, Garcia de Alba Garcia J, et al: *usto* and *nervios*: expressions for stress and depression. *Cult Med Psychiatry* 32(3):406–420, 2008

Shenjing shuairuo

Shenjing shuairuo (“weakness of the nervous system” in Mandarin Chinese) is a cultural syndrome that integrates conceptual categories of traditional Chinese medicine with the Western diagnosis of neurasthenia. In the second, revised edition of the *Chinese Classification of Mental Disorders* (CCMD-2-R), *shenjing shuairuo* is defined as a syndrome composed of three out of five nonhierarchical symptom clusters: weakness (e.g., mental fatigue), emotions (e.g., feeling vexed), excitement (e.g., increased recollections), nervous pain (e.g., headache), and sleep (e.g., insomnia) (Lee 1994). *Fan nao* (feeling vexed) is a form of irritability mixed with worry and distress over conflicting thoughts and unfulfilled desires. The third edition of the CCMD (Chinese Society of Psychiatry 2001) retains *shenjing shuairuo* as a somatoform diagnosis of exclusion (Lee and Kleinman 2007). Salient precipitants of *shenjing shuairuo* include work- or family-related stressors, loss of face (*mianzi*, *lianzi*), and an acute sense of failure (e.g., in academic performance) (Kleinman 1986; Lewis-

Fernández et al. 2009). *Shenjing shuairuo* is related to traditional concepts of weakness (*xu*) and health imbalances related to deficiencies of a vital essence (e.g., the depletion of *qi* [vital energy] following overstraining or stagnation of *qi* due to excessive worry) (Lee and Kleinman 2007). In the traditional interpretation, *shenjing shuairuo* results when bodily channels (*jing*) conveying vital forces (*shen*) become dysregulated as a result of various social and interpersonal stressors, such as the inability to change a chronically frustrating and distressing situation (Lee 1994; Lin 1989). Various psychiatric disorders are associated with *shenjing shuairuo*, notably mood, anxiety, and somatic symptom disorders. In medical clinics in China, however, up to 45% of patients with *shenjing shuairuo* do not meet criteria for any DSM-IV disorder (Chang et al. 2005).

Related conditions in other cultural contexts: Neurasthenia-spectrum idioms and syndromes are present in India (*ashaktapanna*) (Paralikar et al. 2011) and Japan (*shinkei-suijaku*) (Lin 1989), among other settings. Other conditions, such as brain fog syndrome (Ola and Igbokwe 2011), burnout syndrome (Leone et al. 2011), and chronic fatigue syndrome (Fukuda et al. 1994), are also closely related.

Related conditions in DSM-5: Major depressive disorder, persistent depressive disorder (dysthymia), generalized anxiety disorder, somatic symptom disorder, social anxiety disorder, specific phobia, posttraumatic stress disorder.

References

- Chang DF, Myers HF, Yeung A, et al: Shenjing shuairuo and the DSM-IV: diagnosis, distress, and disability in a Chinese primary care setting. *Transcult Psychiatry* 42(2):204–218, 2005
- Chinese Medical Association and Nanjing Medical University: Chinese Classification of Mental Disorders, 2nd Edition, Revised (CCMD-2-R). Nanjing, China, Dong Nan University Press, 1995
- Chinese Society of Psychiatry: The Chinese Classification and Diagnostic Criteria of Mental Disorders, Version 3 (CCMD-3). Ginan, China, Chinese Society of Psychiatry, 2001
- Fukuda K, Straus SE, Hickie I, et al: The chronic fatigue syndrome: a comprehensive approach to its definition and study. International Chronic Fatigue Syndrome Study Group. *Ann Intern Med* 121(12):953–959, 1994
- Kleinman A: Social Origins of Distress and Disease: Depression, Neurasthenia, and Pain in Modern China. New Haven, CT, Yale University Press, 1986

- Lee S: The vicissitudes of neurasthenia in Chinese societies: where will it go from the ICD-10? *Transcult Psychiatry* 31(2):153–172, 1994 10.1177/136346159403100205
- Lee S, Kleinman A: Are somatoform disorders changing with time? The case of neurasthenia in China. *Psychosom Med* 69(9):846–849, 2007
- Leone SS, Wessely S, Huibers MJ, et al: Two sides of the same coin? On the history and phenomenology of chronic fatigue and burnout. *Psychol Health* 26(4):449–464, 2011
- Lewis-Fernández R, Guarnaccia PJ, Ruiz P: Culture-bound syndromes, in Kaplan & Sadock's *Comprehensive Textbook of Psychiatry*, 9th Edition. Edited by Sadock VJ, Sadock VA, Ruiz P. Philadelphia, PA, Lippincott Williams & Wilkins, 2009, pp 2519–2538
- Lin TY: Neurasthenia revisited: its place in modern psychiatry. *Cult Med Psychiatry* 13(2):105–129, 1989 2766788
- Ola BA, Igboke DO: Factorial validation and reliability analysis of the Brain Fog Syndrome Scale. *Afr Health Sci* 11(3):334–340, 2011 22275921
- Paralikar V, Agashe M, Sarmukaddam S, et al: Cultural epidemiology of neurasthenia spectrum disorders in four general hospital outpatient clinics of urban Pune, India. *Transcult Psychiatry* 48(3):257–283, 2011

Susto

Susto (“fright”) is a cultural explanation for distress and misfortune prevalent among some Latinos in the United States and among people in Mexico, Central America, and South America. It is not recognized as an illness category among Latinos from the Caribbean (Weller et al. 2002). *Susto* is an illness attributed to a frightening event that causes the soul to leave the body and results in unhappiness and sickness, as well as difficulties functioning in key social roles (Rubel et al. 1984; Villaseñor-Bayardo 2008). Symptoms may appear any time from days to years after the fright is experienced. In extreme cases, *susto* may result in death. There are no specific defining symptoms for *susto* (Zolla 2005); however, symptoms that are often reported by people with *susto* include appetite disturbances, inadequate or excessive sleep, troubled sleep or dreams, feelings of sadness, low self-worth or dirtiness, interpersonal sensitivity, and lack of motivation to do anything. Somatic symptoms accompanying *susto* may include muscle aches and pains, cold in the extremities, pallor, headache, stomachache, and diarrhea. Precipitating events are diverse, and

include natural phenomena, animals, interpersonal situations, and supernatural agents, among others (Ruíz Velasco 2010).

Three syndromic types of *susto* (referred to as *cibih* in the local Zapotec language) have been identified, each having different relationships with psychiatric diagnoses (Taub 1992). An interpersonal *susto* characterized by feelings of loss, abandonment, and not being loved by family, with accompanying symptoms of sadness, poor self-image, and suicidal ideation, seemed to be closely related to major depressive disorder. When *susto* resulted from a traumatic event that played a major role in shaping symptoms and in emotional processing of the experience, the diagnosis of posttraumatic stress disorder appeared more appropriate. *Susto* characterized by various recurrent somatic symptoms—for which the person sought health care from several practitioners—was thought to resemble a somatic symptom disorder.

Related conditions in other cultural contexts: Similar etiological concepts and symptom configurations are found globally (Simons 1985). In the Andean region, *susto* is referred to as *espanto* (Tousignant 1979).

Related conditions in DSM-5: Major depressive disorder, posttraumatic stress disorder, other specified or unspecified trauma and stressor-related disorder, somatic symptom disorders.

References

- Rubel AJ, O'Neill CW, Collado-Ardón R: *Susto: A Folk Illness*. Berkeley, University of California Press, 1984
- Ruíz Velasco ME: La cosmovisión de la salud y los “peligros del alma” en la zona de los Altos de Chiapas [The worldview of health and the “perils of the soul” in the Chiapas Highlands]. *Atopos* 10:83–100, 2010. Available at: http://www.atopos.es/pdf_10/5_La%20cosmovisi%C3%B3n%20de%20la%20salud%20y%20los%20peligros%20del%20alma.pdf. Accessed December 14, 2012.
- Simons RC: Introduction: the fright illness taxon, in *The Culture-Bound Syndromes: Folk Illnesses of Psychiatric and Anthropological Interest*. Edited by Simons RC, Hughes CC. Dordrecht, Holland, D Reidel, 1985, pp 329–331
- Taub B: *Calling the soul back to the heart: soul loss, depression and healing among indigenous Mexicans*. Unpublished doctoral dissertation, University of California, Los Angeles, 1992
- Tousignant M: *Espanto: a dialogue with the gods*. *Cult Med Psychiatry* 3(4):347–361, 1979

- Villaseñor-Bayardo S: Apuntes para una etnopsiquiatría mexicana. Guadalajara, Mexico, Universidad de Guadalajara, 2008
- Weller SC, Baer RD, de Alba Garcia JG, et al: Regional variation in Latino descriptions of *susto*. *Cult Med Psychiatry* 26(4):449–472, 2002
- Weller SC, Baer RD, Garcia de Alba Garcia J, et al: *Susto* and *nervios*: expressions for stress and depression. *Cult Med Psychiatry* 32(3):406–420, 2008
- Zolla C: La medicina tradicional indígena en el México actual [Traditional indigenous medicine in Mexico today]. *Arqueología Mexicana* 13(74):62–168, 2005. Available at: <http://www.arqueomex.com/S2N2SUMARIO74.html>. Accessed December 14, 2012.

Taijin kyofusho

Taijin kyofusho (“interpersonal fear disorder” in Japanese) is a cultural syndrome characterized by anxiety about and avoidance of interpersonal situations due to the thought, feeling, or conviction that one’s appearance and actions in social interactions are inadequate or offensive to others (Nakamura et al. 2002; Tarumi et al. 2004). In the United States, the variant involves having an offensive body odor and is termed *olfactory reference syndrome*. Individuals with *taijin kyofusho* tend to focus on the impact of their symptoms and behaviors on others (Kinoshita et al. 2008). Variants include major concerns about facial blushing (erythrophobia), having an offensive body odor (olfactory reference syndrome), inappropriate gaze (too much or too little eye contact), stiff or awkward facial expression or bodily movements (e.g., stiffening, trembling), or body deformity (Takahashi 1989).

Taijin kyofusho is a broader construct than social anxiety disorder in DSM-5 (Tarumi et al. 2004). In addition to performance anxiety, *taijin kyofusho* includes two culture-related forms: a “sensitive type,” with extreme social sensitivity and anxiety about interpersonal interactions, and an “offensive type,” in which the major concern is offending others. As a category, *taijin kyofusho* thus includes syndromes with features of body dysmorphic disorder as well as delusional disorder. Concerns may have a delusional quality, responding poorly to simple reassurance or counterexample.

The distinctive symptoms of *taijin kyofusho* occur in specific cultural contexts and, to some extent, with more severe social anxiety across cultures (Choy et al. 2008; Kim et al. 2008). Similar syndromes are found in Korea

and other societies that place a strong emphasis on the self-conscious maintenance of appropriate social behavior in hierarchical interpersonal relationships. *Taijin kyofusho*—like symptoms have also been described in other cultural contexts, including the United States, Australia, and New Zealand.

Related conditions in other cultural contexts: *Taein kong po* in Korea (Choy et al. 2008).

Related conditions in DSM-5: Social anxiety disorder, body dysmorphic disorder, delusional disorder, obsessive-compulsive disorder, olfactory reference syndrome (a type of other specified obsessive-compulsive and related disorder). Olfactory reference syndrome is related specifically to the *jikoshu-kyofu* variant of *taijin kyofusho*, whose core symptom is the concern that the person emits an offensive body odor (Suzuki et al. 2004). This presentation is seen in various cultures outside Japan.

References

- Choy Y, Schneier FR, Heimberg RG, et al: Features of the offensive subtype of Taijin-Kyofu-Sho in US and Korean patients with DSM-IV social anxiety disorder. *Depress Anxiety* 25(3):230–240, 2008
- Kim J, Rapee RM, Gaston JE: Symptoms of offensive type Taijin-Kyofusho among Australian social phobics. *Depress Anxiety* 25(7):601–608, 2008
- Kinoshita Y, Chen J, Rapee RM, et al: Cross-cultural study of conviction subtype Taijin Kyofu: proposal and reliability of Nagoya-Osaka diagnostic criteria for social anxiety disorder. *J Nerv Ment Dis* 196(4):307–313, 2008
- Nakamura K, Kitanishi K, Miyake Y, et al: The neurotic versus delusional subtype of taijin-kyofu-sho: their DSM diagnoses. *Psychiatry Clin Neurosci* 56(6):595–601, 2002
- Suzuki K, Takei N, Iwata Y, et al: Do olfactory reference syndrome and jiko-shu-kyofu (a subtype of taijin-kyofu) share a common entity? *Acta Psychiatr Scand* 109(2):150–155, 2004
- Takahashi T: Social phobia syndrome in Japan. *Compr Psychiatry* 30(1):45–52, 1989
- Tarumi S, Ichimiya A, Yamada S, et al: Taijin kyofusho in university students: patterns of fear and predispositions to the offensive variant. *Transcult Psychiatry* 41(4):533–546, 2004

This page intentionally left blank

Cultural Formulations of Case Examples Seen in the Videos

Russell F. Lim, M.D., M.Ed.

Hendry Ton, M.D., M.S.

This appendix contains the cultural formulations of the four patients interviewed by Dr. Boehnlein and one patient interviewed by Dr. Ton. These formulations are meant to supplement the video excerpts and to provide some context to the video excerpts of each patient. When possible, cases are cross-referenced with scenes from the interviews.

Chapter 2: Vietnamese American Case— Mr. Tran

Mr. Tran is a 54-year-old Vietnamese American man who presents at the initial visit to a psychiatrist complaining of headaches and problems sleeping. He

has been suffering from years of untreated depression and posttraumatic stress disorder (PTSD) but has been reticent to tell others because of the stigma of having a mental health issue.

Cultural Identity

Mr. Tran immigrated to the United States in 1988 as a refugee. He was born in Saigon to a financially comfortable family. He joined the South Vietnamese Army during the final days of the war and was one of a few soldiers to survive as the North Vietnamese forces swept through South Vietnam. He was captured and placed in a reeducation camp for several years. He and his family struggled economically after the war and experienced ongoing government persecution for his role in the war. In 1986, he escaped Vietnam by boat and made his way to the refugee camps in Thailand, where he stayed for 2 years. Eventually, his immigration to America was sponsored by a relative. Several years later, he met his wife, a fellow Vietnamese American refugee.

Mr. Tran currently lives in Oakland, California, with his wife and two children. He struggles with his identity as a Vietnamese father and husband. Because of limited English proficiency and his mental health condition, Mr. Tran has not been able to maintain employment. He maintains traditional Vietnamese family values and has particular difficulties coping with his inability to provide for his family. He worries that traditional cultural values and history are lost to his children and notices the increasing gulf in communication and harmony within his family as a result. However, as his parents did before him, Mr. Tran has always emphasized education with his children. He and his wife have given up their own material comforts in order to make sure his children have the books and school materials they need, and he is pleased that they are doing well in school.

Cultural Conceptualizations of Distress (Video 2-1)

Mr. Tran feels guilty about having emotional problems and fears that he will lose even more respect among his family members and friends if he openly shares these difficulties. He worries that many of his emotional problems are due to his own moral weakness and perhaps are a result of an imbalance of the “hot” and “cold” energies in his body. In Vietnamese culture, “hot” and “cold” imbalance is considered to be a predominant cause of illness. Mr. Tran has

struggled for years with his symptoms and has tried various herbal remedies suggested by acquaintances for “sleeping problems and headaches” without much relief. Despite concerns that he has heard from members of his community about Western medications causing addiction, “hotness,” and powerful side effects, he is now willing to consider going to a psychiatrist. Although Mr. Tran experiences symptoms of PTSD and major depressive disorder, his idioms of distress are predominantly somatic and cognitive rather than emotional and include poor concentration, insomnia, and lack of energy. Emotional symptoms are more likely to be subject to stigma in traditional Vietnamese culture. After prompting from Dr. Ton that his experience is important for the psychiatrist to know, Mr. Tran also attributes his difficulties to mortar fire.

Psychosocial Stressors and Cultural Features of Vulnerability and Resilience

Mr. Tran lives and socializes predominantly within the Vietnamese American community in Oakland. He avoids interactions with English-speaking communities mainly because of language and cultural barriers. However, his relationships among his peers are limited by his sense of shame caused by his inability to maintain work. Many traditional Vietnamese hold the predominant patriarchal values, which emphasize that the primary financial provider and decision-making authority should be the male head of the household. Mr. Tran’s mental health condition has made it challenging for him to fulfill these cultural expectations. This is further exacerbated by his limited English proficiency, which significantly narrows his opportunities for employment and his awareness of and ability to engage with other societal resources.

Given the stigma of mental illness, Mr. Tran fears being further marginalized in his community if it were known that he is seeking treatment. Differential levels of acculturation between him and his children also cause stress on the family system. This has resulted in role reversals in which his children have more expertise with accessing societal resources. However, cultural factors have also contributed positively to Mr. Tran’s psychosocial health and functioning. His strong sense of family has instilled in him a sense of purpose and meaning with regard to supporting his children’s education. The value of filial piety also influences how his family treats him, and it preserves some acknowl-

edgment of his authority and dignity. Despite the negative impact of differential acculturation, his children are able to help him understand American culture, and, as a result, he has endorsed involvement of some Western social and mental health services.

Cultural Features of the Relationship Between the Individual and the Clinician

Mr. Tran is initially reticent about seeing a Vietnamese psychiatrist because of fears that the psychiatrist's social relationships might overlap with his, which could result in disclosure of his struggles to others in the community. Additionally, he worries that he would be judged as having "poor character" or "poor family upbringing" by another Vietnamese person, thus reinforcing his own sense of failure. He may also feel some discomfort in receiving care and guidance from a younger member of his culture, which parallels his struggles with role reversals within his family. However, his relationship with the psychiatrist has the potential to model healthier interactions with younger Vietnamese people and raise new insights on how to interact with other Vietnamese in the context of his mental health conditions. Mr. Tran may also be comforted knowing that the psychiatrist is familiar with the values, beliefs, and experiences of Vietnamese people—something he feels is being lost among younger Vietnamese Americans.

Overall Cultural Assessment (Video 2–2)

Culture has a strong influence on Mr. Tran's identity, his perspectives on illness and healing, and his relationships and psychosocial supports. This presents opportunities and challenges to the therapeutic relationship and to his overall mental health treatment. Mr. Tran's psychiatrist, Dr. Ton, who is also Vietnamese, must attempt to use his own experiences and familiarity with the culture to bolster and inform the therapeutic relationship while also maintaining boundaries that reassure the patient that the stigma that he fears exists in the Vietnamese community will not manifest in their relationship. Dr. Ton uses the cultural formulation to guide the interview and treatment planning process.

In their initial encounter, Mr. Tran focuses on somatic concerns. Dr. Ton recognizes this as a potential idiom for depression and inquires about emo-

tional suffering in a face-saving manner. Feeling acknowledged, Mr. Tran begins to disclose his emotional and familial struggle. Dr. Ton encourages Mr. Tran to expand on his familial and psychosocial experiences, sensing that this is an important part of Mr. Tran's identity. He then attempts to find aspects of Mr. Tran's relationship with his children that positively support his cultural identity. Mr. Tran's spirits lift during this discussion, and he feels that Dr. Ton also appreciates his strengths and resilience. With their therapeutic relationship bolstered, Mr. Tran feels safer discussing highly stigmatizing symptoms. Dr. Ton attempts to reduce the stigma by acknowledging Mr. Tran's distress and then normalizing it, drawing on his education and expertise. Mr. Tran finds some comfort in this because he also values education. Dr. Ton proceeds to inquire about Mr. Tran's explanation of his illness and then attempts to develop a collaborative explanatory model that also incorporates the biopsychosocial perspective. He then segues into a discussion of medications. Mr. Tran shares a common Vietnamese concern about psychiatric medications, and Dr. Ton utilizes his prior knowledge about this belief to add more context about the medications and emphasizes the collaborative nature of their work together. Mr. Tran, feeling reassured and culturally understood, expresses his wish to move forward with the treatment plan (Video 2–2).

Chapter 3: African American Case—Mr. Jones

Mr. Jones is a 32-year-old married African American man who is a computer network administrator for San Francisco State University. His wife, Tina, is an African American lawyer working at her father's firm. Mr. Jones presents because a few weeks ago he forgot to pick up his daughter from day care because he was too tired. "I'm not acting like myself," he states. He describes his life as being "Mr. Mom." He has been feeling this way for at least a year, but he has felt worse in the last few months. His wife asked him to get help, and he asked her to make the appointment for him. He complains of fatigue and irritability and of people, including his supervisor, "buggin' me" to get his work done on time. He states that his wife is a workaholic and that it is his job to pick up their 2-year-old daughter, Brittany, from day care because of his wife's unavailability during her 10- to 12-hour workdays. Her work schedule has significantly affected their relationship, and they rarely have sexual relations. They argue frequently. He complains of early-morning awakening, alternating with days when he has difficulty waking up.

Cultural Identity of the Individual (Videos 3–1 and 3–2)

Mr. Jones is from Oakland, California, and has a working-class background. His mother was a teacher, and his father was a construction worker and a strict disciplinarian. His parents still live in Oakland. His maternal grandfather died when he was 23, and his maternal grandmother, with whom he was quite close, died 2 years ago. One of his cousins was murdered. He is the oldest of three siblings and is the only person among his friends to get a college degree, having attended San Francisco State University on a scholarship and graduating with a degree in computer science. He was a good student and was on the basketball and track teams. He described a sheltered childhood, although some of his friends were “hoodlums.” He was never involved in drugs or alcohol. He had some “run-ins” with gangs, getting beat up and a couple of black eyes, and considers himself lucky not to have gotten shot: “It was rough.” His sister, 5 years younger, is studying for a master’s degree in social work and is living in Oakland with their parents, and his brother, 2 years younger, is a teacher and is engaged.

Mr. Jones lives in a townhouse, bought for him and his wife by his in-laws, in the Pacific Heights area of San Francisco. His in-laws also gave him a membership to a country club, but he does not feel as if he fits in. Mr. Jones appears to have left his childhood behind him, but in comparison to his wife’s family, he has not achieved much and likely feels unappreciated by them, much as he had felt unappreciated by his parents. He seems to feel uncomfortable with both his working-class background and his wife’s upper-class background. He stated that it felt “weird” to be given things, such as the townhouse or the country club membership. He seems resentful of his in-laws’ wealth and social position and feels that he is a disappointment to them, and despite all of his efforts to improve his social standing by going to college, he doesn’t quite fit in with their world.

Cultural Conceptualizations of Distress

Mr. Jones sees his problems mostly in terms of his physical symptoms and problems in his relationship and not as a mental disorder. He denies that he is depressed. Mr. Jones does not believe in medications, feeling that they are habit forming, and he is afraid of addiction and dependence. He would also be embarrassed if anyone knew that he was taking a medication. He thinks that this is a psychological problem that he can solve on his own and feels that he is

acting as his father would by “holding things back.” Although skeptical that he has a mental illness, he is open to the idea of psychotherapy because he would not have to take a medication and he could learn not to be like his father.

Psychosocial Stressors and Cultural Features of Vulnerability and Resilience (Videos 3–2 and 3–5)

Mr. Jones was raised as a Baptist and married a Catholic. His wife goes with him to his Christian church in Pacific Heights, but he notes that it is not the same as going to church in Oakland, another example of lack of comfort with his life choices and social environment. His maternal grandfather died when he was 23, and his maternal grandmother, who helped to raise him, died just before his daughter was born, causing him to feel disappointed and sad because she never saw her great-grandchild. He is isolated from his high school friends, extended family, wife, and church. He complains about a lack of sexual intimacy with his wife and not spending enough time together. He feels uncomfortable with his role in his family. He provides much of the child care for their daughter but also continues to work outside the home, even though that is not financially necessary because his wife earns a good salary. His wife is ambitious and wants to be a senior partner, which requires her to work long hours. Moreover, Mr. Jones would like to have another child now rather than wait for a few more years. He also feels that his in-laws do not quite understand him.

Cultural Features of the Relationship Between the Individual and the Clinician (Video 3–6)

Mr. Jones does not feel that the psychiatrist understands his situation and wonders if he is married. He does not feel that his psychiatrist can understand his working-class roots, asking him, “Doc, you ever been to East Oakland?” Dr. Boehnlein acknowledges the differences between them and reassures the patient that he will be understood.

The therapist needs to pay attention to the class dynamics because the patient will likely see him as he does his in-laws, belonging to an upper social class and thus being unable to really understand him. He also may be skeptical of the therapist’s ability to understand his ongoing struggle to reconcile his ambivalence about his social class.

Overall Cultural Assessment

Mr. Jones, like many African Americans, is mistrustful of psychiatrists and medications. Mr. Jones feels that he does not fit into either his family of origin's working-class world or his wife's upper-class world, and this may be acted out in the therapeutic relationship between the patient and the therapist. He also believes that psychiatric medications are dangerous and addictive. The clinician reassures the patient of the nonaddictive properties of medications, and the treatment is not forced on the patient.

Mr. Jones accepts the offer of psychotherapy, as he may be beginning to trust the therapist to understand his experience. There also are important therapeutic issues beyond culture, such as dealing with loss and life stage changes. Mr. Jones's maternal grandmother died before the birth of his daughter, and he cannot relate to his friends from high school. His family role is defined as the primary caregiver, and he feels that he must work to fulfill his role as a husband because he is not a major contributor to the family income. Dr. Boehnlein would like to do some couples counseling because part of the stress in Mr. Jones's life is related to his wife's professional work and its effect on the family and their relationship. Mr. Jones is open to the idea that his wife should come to some therapy sessions but is ambivalent about its usefulness, as evidenced by his slight nod at Dr. Boehnlein's suggestion.

Chapter 4: Asian American Case—Mr. Chen

Mr. Chen is a 47-year-old married Chinese immigrant with a U.S. doctoral degree in engineering who comes in because his wife and parents asked him to. He has been unemployed for 2 years after losing his job as an electrical engineer. He states that he has been feeling sad for the past 4 years and has been irritable and has been experiencing insomnia, poor memory, fatigue, hopelessness, an increase in weight, backaches, and headaches, but denies suicidal ideation. He stays home frequently because he does not feel like going out. He does not do household chores because he sees that as "women's work."

Cultural Identity of the Individual (Video 4-1)

Mr. Chen is a 47-year-old Chinese man from Beijing, China. He is the oldest of two sons and immigrated to the United States 14 years ago to obtain a doc-

torate in electrical engineering. His adjustment to living in the United States was difficult because his English was poor. He did not have much support from friends or relatives. His father is an engineer, and his mother is a teacher. His younger brother is the favorite and is married and just had a son. Mr. Chen is upset and ashamed that he is not fulfilling his role as the breadwinner and that his wife is expecting him to do housework. He is a very private individual and does not want the therapist talking about his business. His wife has talked to his colleagues about his problems in the past, which has upset him.

Cultural Conceptualizations of Distress (Video 4–2)

Mr. Chen recognizes his symptoms as being similar to those of his mother, who had *shenjing shuairuo*, but he does not believe that is the cause of his problem. *Shenjing shuairuo* is a condition seen in China that is notable for physical and mental fatigue, dizziness, headaches, other pains, concentration difficulties, sleep disturbance, and memory loss. Other symptoms can include nausea, sexual dysfunction, and irritability. There is some overlap with major depressive disorder. The diagnosis is included in the *Chinese Classification of Mental Disorders*, Second Edition (CCMD-2), and can also be found in the DSM-5 Glossary of Cultural Concepts of Distress (see Appendix 2). Mr. Chen has tried acupuncture because he had heard that it was effective, and herbalists, as suggested by his parents. However, he saw the herbal treatment as smelly teas with a bad taste and odor that did not help him feel better. He enjoys talking with his acupuncturist and shares his belief that his problem is caused by an imbalance in *qi* or vital energy and that his *qi* can be redirected by the needles placed in his meridians. He sees himself as just not having enough energy and does not accept that he has a psychiatric problem because that would mean that he is “crazy.” Having a mental diagnosis carries a great deal of stigma in Chinese culture. He also sees himself as a victim of fate or bad luck, a Buddhist belief, and believes that if he just works harder, he will improve. Despite feeling sad, Mr. Chen does not cry, probably because of the teachings of Confucianism, which emphasize strict control of emotions or stoicism as well as respect for parents and elders.

Psychosocial Stressors and Cultural Features of Vulnerability and Resilience (Video 4–3)

Mr. Chen is aware that his parents prefer his younger brother, who recently had a son, the family's first grandchild. Although Mr. Chen is married, he is childless. Mr. Chen feels that his brother took his role as the eldest son and that his parents are disappointed in him because he was expected to have the first grandson. He speaks to his parents in China by telephone regularly and seeks to gain their approval by following their advice. His parents are disappointed that he does not visit them more often in China. Mr. Chen feels inhibited from inviting his parents for a visit because he has no home for them to stay in during their visit.

Mr. Chen values his privacy and is upset when his wife talks about their problems to her friends. Furthermore, he has been relegated to cooking and taking out the garbage, tasks that he feels his wife should do. He feels that his wife does not respect him because he does not have a job. He feels that he has let down his wife, his parents, and himself by not being able to get a job but resents being asked to pitch in around the house. He also worries that his wife is having an affair because she goes out without him. He and his wife used to volunteer for a service organization for the community but no longer do so. He has few friends and stays in touch with his brother through e-mail.

As a Buddhist, he is a firm believer in fate and feels that there is not much he can do to change his situation. Mr. Chen belongs to a Buddhist temple but does not go often. He is proud of his educational achievements but is disappointed in himself for being unable to find a job that matches his qualifications.

Cultural Features of the Relationship Between the Individual and the Clinician

Mr. Chen denies that he has a mental illness because he would be shamed if it were known that he has one. He is uncomfortable sharing family secrets with a stranger and demands a guarantee of confidentiality. He is impatient with the doctor because he does not see a connection between the questions he is being asked and his getting better. Mr. Chen also is not willing to share the details of his sex life with his psychiatrist because it is a social taboo to share such intimate matters. The psychiatrist is surprised by the patient's short temper and uses empathy to hide his discomfort and to repair the therapeutic alliance.

The therapist is also surprised by the patient's impatience with his asking what has been helpful and then takes a more active role in the treatment discussion, as per Mr. Chen's expectations.

The patient does not make eye contact because that would be disrespectful. This might be interpreted as resistance or mistrust by Western-trained psychiatrists, but in Mr. Chen's case, it is normative. The therapist should also be aware that most communication among Asians is indirect and should be able to interpret the patient's history accordingly, as well as not suggest that the patient be more direct. The patient also expects the doctor to tell him what condition he has and what he should do about it, which explains his disappointment that Dr. Boehnlein is not giving him a straight answer about his condition.

Overall Cultural Assessment

The psychiatrist supports Mr. Chen's use of an acupuncturist because the practice does him no harm and he derives benefit from talking with him. This also is a strategy for bridging two explanatory models of treatment and causation. Dr. Boehnlein prescribes a selective serotonin reuptake inhibitor to target Mr. Chen's lack of energy, poor sleep, and irritability. He reassures Mr. Chen that he is not crazy and labels his illness as a physical illness called depression. Mr. Chen is reluctant to accept this, but it is more acceptable to him than a psychological explanation of depression. The doctor does not use the patient's term *shenjing shuairuo* because he understands that the patient does not accept this model.

Although Mr. Chen is defensive about his wife coming to sessions, the psychiatrist suggests it because he sees that the deteriorating relationship between the patient and his wife is a major contributor to his continuing depression. However, Mr. Chen wants them to meet separately, which is an indication of his hopelessness that things can improve between him and his wife, another example of his fatalism, and another projection of his problems onto others. Having the couple meet together should be a goal of therapy because it assumes that both parties have a role in the conflict. However, reaching this goal may be problematic because the patient feels that little can be accomplished.

Dr. Boehnlein abandons the collaborative model for the authoritarian style when he recognizes that Mr. Chen wants him to make the treatment decisions.

Chapter 5: Latino Case—Mrs. Santiago

Mrs. Santiago is a 52-year-old twice-married Nicaraguan woman living in San Francisco, with an episode of “going crazy” just before her scheduled departure for Nicaragua. Her husband of 23 years had left her 3 weeks prior to her episode, taking all of the money that they had saved for their retirement, and began living with his 21-year-old girlfriend of 6 months in the Santiagos’ dream retirement home in Nicaragua. The week before her episode, her husband had asked Mrs. Santiago to come to Nicaragua to be with him, to take care of him, and live with him and his new girlfriend because “she took care of him the best.” She bought herself an airplane ticket and made plans to join him before her episode, despite her 23-year-old daughter’s advice to stay in the United States. The day of her scheduled flight to Nicaragua, she “lost it” and was rolling on the bed, banging her head against the wall, screaming and crying, and yelling at everyone to leave her alone. She did not recall all of the events leading to her hospitalization. Her daughter called 911, and she was taken by ambulance to the hospital, evaluated, and later released. She noted that prior to her attack, she was distracted and had racing thoughts, had lost 5 pounds as a result of a loss of appetite, and complained of feeling angry with her second husband. Mr. Santiago was described as an alcoholic and a womanizer (*mujeriego*), both of which Mrs. Santiago had tolerated. He had both physically and verbally abused her, telling her that she was “fat, ugly,” and that he was “tired of her,” but she had not told anyone of these events because she was afraid of what people would say.

Cultural Identity of the Individual (Video 5–2)

Mrs. Santiago is a Nicaraguan immigrant from a small town near Managua. Her mother was a teacher, and her father owned a store. She described her childhood as strict, and she was raised as a Pentecostal. When she was 28, her mother died of breast cancer, and her father died 2 years later in a car accident when she was 30. She is the oldest of four children, with one younger sister (1 year younger) and two younger brothers (2.5 and 8 years younger). She left Nicaragua and immigrated to the United States primarily to escape from her physically abusive first husband. Her parents never approved of her first husband. Her adjustment to the United States was difficult because she knew little English. She went to night school to learn English and worked as a housekeeper or as a child-care worker during the day. She knew few people in San Francisco except friends of her family and had no relatives or family in the Bay Area. She worried about her

legal status, and when she met Mr. Santiago, he represented a “solution” because he was a U.S. citizen. Her marriages have been marked by domestic violence, both physical and verbal, but she has been inhibited from ending them because of her responsibility as a wife and her religious beliefs that prohibit divorce.

Cultural Conceptualizations of Distress (Video 5–1)

Mrs. Santiago’s symptoms meet the criteria for an acute anxiety disorder, but she would recognize it as a DSM-5 cultural concept of distress, an *ataque de nervios*. Symptoms usually include uncontrollable shouting, attacks of crying, trembling, and verbal or physical aggression. Patients may also have dissociative experiences or fainting episodes. Many patients experiencing an *ataque de nervios* report a sense of being out of control. An *ataque* usually occurs as a direct result of a stressful family event such as the death of a close relative, separation or divorce from a spouse, or conflicts with a spouse or children. Patients may also experience amnesia for what occurred during the *ataque de nervios*, but they otherwise return rapidly to their usual level of functioning.

Mrs. Santiago had been seen at Mission Mental Health in the past and was referred to a psychiatrist, but she never made the appointment, most likely because of her perception of the stigma of having a mental illness. She also uses some fatalism to deal with her losses. “What else can you do?” she says at one point.

Psychosocial Stressors and Cultural Features of Vulnerability and Resilience (Video 5–3)

Divorce is not supported by Mrs. Santiago’s Pentecostal faith or her culture. She had to leave Nicaragua to leave her first husband, thus avoiding pressure from her community and family to stay with him. Her parents died when she was an adult. Her siblings are distant from her. In San Francisco, she does not have many friends, but she does have her daughter’s support. She now lives with her daughter and 6-year-old grandson. She is upset that her daughter got involved with gangs when she was young and got pregnant when she was 17 but feels that her daughter is a good person. She finds it embarrassing to attend church and rarely goes. She celebrates her mother’s birthday and the anniversary of her death by going to church and going to the beach. Mr. Santiago was described as an alcoholic and a womanizer, as well as someone

prone to announcing that he was going to kill himself, but she accepted all of his behavior, even when he physically abused her. In her current marriage, Mrs. Santiago is also following the values of *marianismo*: that she must be the one to make sacrifices for the marriage.

Cultural Features of the Relationship Between the Individual and the Clinician

Mrs. Santiago tells Dr. Boehnlein how difficult it is for her to discuss her private matters with a stranger by her use of a Spanish metaphor, “*No saques los trapos afuera*” (“Don’t take the rags outside”). Dr. Boehnlein responds to this with another metaphor, “Secrets aren’t helpful” (not shown), which the patient finds useful. She feels comfortable with a white therapist, most likely because she does not have to follow the strict gender expectations of her culture and she can be more honest with him than she would with a Latino therapist.

Overall Cultural Assessment

Mrs. Santiago’s symptoms serve a protective function for her, bringing her attention and help from her family. Having an *ataque* prevents her from fulfilling her obligation to honor and obey her spouse, part of *marianismo*, which involves self-denial on the part of the wife/mother to take care of others, without the shame of disobeying her husband’s wishes, no matter how unreasonable. Other aspects of *marianismo* include sacred duty to family, subordination to men, subservience, selflessness, self-renouncement and self-sacrifice, chastity before marriage, sexual passivity after marriage, and erotic repression.

Mrs. Santiago is willing to meet with Dr. Boehnlein for therapy and is hopeful that her condition will improve. She asks Dr. Boehnlein if she needs medication and is relieved to find that she does not need it. Many patients will not ask directly for a medication unless it is offered, but perhaps Mrs. Santiago has done some research, has talked to a friend, or had been offered medications at Mission Mental Health. Dr. Boehnlein should continue to use metaphors, pay attention to Mrs. Santiago’s use of Spanish words, and consider using a Spanish interpreter for therapy to better understand the patient’s feelings in her native language and as a cultural broker to understand the gender roles of a Latina woman. The therapist must also be respectful of Mrs. Santiago’s fear of stigma, as well as her culturally determined gender roles, and be

cautious of suggesting Western-themed attitudes for her to consider because she would view these to be in opposition to *marianismo*. The therapist also should be aware that general developmental and family issues not specific to culture may influence her identity and behavior, such as her family position as the oldest daughter continuing to influence her need to care for and sacrifice for others.

Chapter 7: White Euro-American Case— Ms. Diamond

Ms. Diamond is a 38-year-old single Jewish American woman from Trumbull, Connecticut, who is living in Manhattan and working as a legal secretary. She came in for the treatment of depression that she has had for many years, stating that she is depressed and not happy. She reports chronic unhappiness, starting from her teenage years, with poor self-esteem and body image. Ms. Diamond also has problems with fatigue and insomnia, falling asleep at 2:00 A.M. and sleeping only 2–3 hours per night. She finds her work “annoying,” sees extra work as an imposition on her time, and calls in sick at least once a month. She does not take vacations anymore because they are “too much of a hassle.” She has been in treatment for many years with four or five different therapists, including group therapy, at ages 16, 20, and 25 but remains irritable, sad, guilty, and lonely. Her last therapist was a Jewish woman, who understood her well but retired abruptly, according to the patient, after 3 years of treatment, and she is looking for a new therapist.

Cultural Identity of the Individual (Video 6–1)

Ms. Diamond is the oldest of three girls. She was never “popular” or one of the “cool” kids. Her younger sisters, ages 30 and 32, were always more “cool” than she was, and she never was part of their “little group.” She has always felt pressured by her parents to excel in school. She attended Hebrew school 3 days a week after her regular school and “hated it.” She had little free time because she also was taking music lessons. Her mother belonged to the Jewish Foundation for the Righteous (which supports the non-Jewish rescuers of Holocaust survivors and promotes education regarding their acts of courage and benevolence) and Hadassah (the Women’s Zionist Organization of America, a philanthropic group that raises money for Israel). Her grandmother was a Holocaust survivor and taught her that she could not trust anyone who was not

Jewish. Her peer groups, including her sisters and a small group of friends, are all married and have children and “perfect families.” They are married to bankers and accountants, and one of her sisters is a dentist.

Ms. Diamond feels obligated to attend family functions and events to which she is invited, although she is very ambivalent about doing so. She would like to marry a Jewish man but has had difficulty meeting one and despairs of growing old. She really wanted children and sees that now as being an unobtainable goal. She is upset that there are so many other grandchildren in her family, and her parents remind her that she is the “single one without children.” She had one significant relationship in college that she thought would lead to marriage, but she was abandoned by her boyfriend after he moved away for medical school and met another woman. She thinks poorly of herself, saying that it is “pathetic” now, 15 years later, to still care about him and what he did to her. At age 35, she had an affair with one of the married partners at her law firm. She told her parents, who did not approve of that relationship because it would not lead to marriage, and she broke up with him soon after. She has tried using dating services, such as JDate for young Jewish professionals, but thought that most of the men were “losers” who all lied in their online profiles about being employed, having a high level of fitness, and attaining a high educational level. This reinforced mistrust of men and people outside of her family. She has a close relationship with her mother and calls her frequently. She feels that she is a disappointment to her parents yet does not understand why she needs their approval. She will not consider suicide because “it’s way against my religion.”

Cultural Conceptualizations of Distress

Ms. Diamond believes that she has depression like her mother and that she can fix her personal problems through psychotherapy. She feels that exercise is helpful. She views the world as an unsafe place where few can be trusted and feels that her freedom of choice is limited by cultural and family values; however, not following these values makes her anxious. She believes, as her grandmother did, that no one can be trusted. Everyone lies, such as her latest dates, or leaves her. She also is disappointed that she has not met her “end points” because she is single and childless and thinks that she is running out of time. Her situation could be seen as a midlife crisis.

Psychosocial Stressors and Cultural Features of Vulnerability and Resilience

Ms. Diamond is having an Eriksonian crisis, often referred to as a midlife crisis. She has not achieved certain “end points,” such as a fulfilling, lucrative, or prestigious job; a stable, intimate relationship; children; or home ownership. Her close association with her mother and family and cultural values increase her awareness of the things that she has not yet accomplished in her life. Her grandmother was a Holocaust survivor, and her first boyfriend abandoned her 2 years into his medical training, proving to her that her family was right that people are not to be trusted. She states that her parents make her feel like “a little kid” and complains that the pressure from her family never “lets up.” However, she feels that she had a special relationship with her grandmother and knew that her grandmother loved her.

Cultural Features of the Relationship Between the Individual and the Clinician (Video 6–2)

Ms. Diamond is looking for a therapist who is Jewish and is looking to re-create the feeling that the therapist was “extended family” and could really understand her. The patient challenges Dr. Boehnlein by asking him, “Are you Jewish?” Dr. Boehnlein answers truthfully that he is not but reassures the patient that he has some familiarity with Jewish culture and is always open to learn more; he invites Ms. Diamond to teach him, so that he can try to understand her as best as he can. She is skeptical of his claim but is willing to meet with him again. She is typical of many “sandwich” generation children who are clearly bicultural and are “caught between two cultures.” She has never fit in with any group or been popular, and she feels inferior to her sisters. She is trying to win her parents’ approval by attending family functions and then blames them for taking up all of her free time. She feels trapped between being a good member of the family and trying to meet her own needs.

Dr. Boehnlein follows up on Ms. Diamond’s comment about the concern that he might be anti-Semitic by asking her if she had experienced anti-Semitism to show the patient that he was aware of discrimination against Jewish people and that he wanted to hear about her experience. She told him that once she had pennies thrown at her, which was upsetting to her. She also expects her therapist to be more active, suggesting that psychoanalysis would

not be the therapeutic method of choice, and stating that she was uncomfortable with therapists who said little and sat in “judgment” of her, a possible projection from the relationship that she has with her parents.

Her many experiences with therapy have left her impatient and skeptical, and she feels as if she is repeating the same old, tired stories and does not want to repeat them again to Dr. Boehnlein.

Overall Cultural Assessment (Video 6–3)

Dr. Boehnlein proposes that to achieve her goal of feeling better, therapy could offer Ms. Diamond a way of seeing her life differently. Although she is skeptical that Dr. Boehnlein is a good match for her, she agrees to a few trial sessions. The therapist should help Ms. Diamond explore her level of adult development and create a trusting relationship in which she can discuss her frustration with her life and the pressure of disappointing her parents by staying single and childless. The therapist must be aware that trust will be a central issue in therapy and that a central dynamic in therapy will be her ongoing suspicion that the therapist is constantly judging her and does not understand her cultural and life stage challenges. Fear of abandonment and rejection will be ongoing issues.

Bibliography

Francis G. Lu, M.D.

Books¹

- Adams N, Grieder DM: *Treatment Planning for Person-Centered Care: Shared Decision Making for Whole Health*, 2nd Edition. San Diego, CA, Academic Press, 2013
- Ahmed S, Amer MM (eds): *Counseling Muslims: Handbook of Mental Health Issues and Interventions*. New York, Routledge, 2011
- Akthar S: *Immigration and Acculturation: Mourning, Adaptation, and the Next Generation*. Lanham, MD, Jason Aronson, 2009
- Akthar S (ed): *Freud and the Far East: Psychoanalytic Perspectives on the People and Culture of China, Japan, and Korea*. Lanham, MD, Jason Aronson, 2010
- Akthar S (ed): *The African American Experience: Psychoanalytic Perspectives*. Lanham, MD, Jason Aronson, 2012
- Akyeampong E, Hill A, Kleinman A (eds): *The Culture of Mental Illness and Psychiatric Practice in Africa*. Bloomington, Indiana University Press, 2014
- Altman N: *The Analyst in the Inner City: Race, Class, and Culture Through a Psychoanalytic Lens*, 2nd Edition. New York, Routledge, 2009
- Barnow S, Balkir N (eds): *Cultural Variations in Psychopathology: From Research to Practice*. Boston, MA, Hogrefe, 2012

¹The top 15 titles are marked with an asterisk.

- Bernal G, Domenech Rodriguez MM (eds): *Cultural Adaptations: Tools for Evidence-Based Practice With Diverse Populations*. Washington, DC, American Psychological Association, 2012
- Berzoff J (ed): *Falling Through the Cracks: Psychodynamic Practice With Vulnerable and Oppressed Populations*. New York, Columbia University Press, 2011
- Berzoff J, Flanagan LM, Hertz P (eds): *Inside Out and Outside In: Psychodynamic Clinical Theory and Psychopathology in Contemporary Multicultural Contexts*, 3rd Edition. Lanham, MD, Rowman & Littlefield, 2011
- Bhattacharya R, Cross S, Bhugra D (eds): *Clinical Topics in Cultural Psychiatry*. London, Royal College of Psychiatrists Publications, 2010
- *Bhugra D, Bhui K (eds): *Textbook of Cultural Psychiatry*. New York, Cambridge University Press, 2007
- Bhugra D, Gupta S (eds): *Migration and Mental Health*. New York, Cambridge University Press, 2010
- Bhugra D, Craig T, Bhui K (eds): *Mental Health of Refugees and Asylum Seekers*. New York, Oxford University Press, 2010
- Bhui K (ed): *Elements of Culture and Mental Health: Critical Questions for Clinicians*. London, Royal College of Psychiatrists Publications, 2013
- Bieschke KJ, Perez RM, DeBord KA (eds): *Handbook of Counseling and Psychotherapy With Lesbian, Gay, Bisexual, and Transgender Clients*, 2nd Edition. Washington, DC, American Psychological Association, 2006
- Brown L: *Cultural Competence in Trauma Therapy: Beyond the Flashback*. Washington, DC, American Psychological Association, 2008
- Cabaj RP, Stein TS (eds): *Textbook of Homosexuality and Mental Health*. Washington, DC, American Psychiatric Press, 1996
- *Carter RT (ed): *Handbook of Racial-Cultural Psychology and Counseling*. Hoboken, NJ, Wiley, 2005
- Chang EC (ed): *Handbook of Adult Psychopathology in Asians: Theory, Diagnosis, and Treatment*. New York, Oxford University Press, 2012
- Chen X, Rubin KH (eds): *Socioemotional Development in Cultural Context*. New York, Guilford, 2011
- Chin JL (ed): *The Psychology of Prejudice and Discrimination: A Revised and Condensed Edition*. Westport, CT, Praeger, 2009
- Chin JL, Liem JH, Domokos-Cheng Ham MA, et al: *Transference and Empathy in Asian American Psychotherapy: Cultural Values and Treatment Needs*. Westport, CT, Praeger, 1993

- Chun KM, Organista PB, Marin G (eds): *Acculturation: Advances in Theory, Measurement, and Applied Research*. Washington, DC, American Psychological Association, 2003
- *Comas-Diaz L: *Multicultural Care: A Clinician's Guide to Cultural Competence*. Washington, DC, American Psychological Association, 2012
- Comas-Diaz L, Greene B (eds): *Psychological Health of Women of Color: Intersections, Challenges, and Opportunities*. Westport, CT, Praeger, 2013
- Culhane-Pera KA, Wawter DE, Phua X, et al (eds): *Healing by Heart: Clinical and Ethical Case Stories of Hmong Families and Western Providers*. Nashville, TN, Vanderbilt University Press, 2003
- Delvecchino M-J, Willen SS, Hannah SD, et al (eds): *Shattering Culture: American Medicine Responds to Cultural Diversity*. New York, Russell Sage Foundation, 2011
- *Fadiman A: *The Spirit Catches You and You Fall Down*. New York, Noonday Press, 1997
- Falicov CJ: *Latino Families in Therapy: A Guide to Multicultural Practice*, 2nd Edition. New York, Guilford, 2013
- Favazza AR: *Bodies Under Siege: Self-Mutilation, Nonsuicidal Self-Injury, and Body Modification in Culture and Psychiatry*, 3rd Edition. Baltimore, MD, Johns Hopkins University Press, 2011
- Galanter M: *Spirituality and the Healthy Mind*. New York, Oxford University Press, 2005
- Gallardo ME (ed): *Developing Cultural Humility: Embracing Race, Privilege and Power*. Thousand Oaks, CA, Sage, 2013
- Gallardo ME, Yeh CJ, Trimble JE, et al (eds): *Culturally Adaptive Counseling Skills: Demonstrations of Evidence-Based Practices*. Thousand Oaks, CA, Sage, 2011
- Gamst GC, Der-Karabetian A, Dana RH (eds): *Readings in Multicultural Practice*. Thousand Oaks, CA, Sage, 2008
- Gardiner HW, Kosmitzki C (eds): *Lives Across Cultures: Cross-Cultural Human Development*, 5th Edition. Saddle River, NJ, Pearson, 2010
- *Griffith JL: *Religion That Heals, Religion That Harms: A Guide for Clinical Practice*. New York, Guilford, 2010
- Griffith JL, Griffith M: *Encountering the Sacred in Psychotherapy: How to Talk With People About Their Spiritual Lives*. New York, Guilford, 2001

- Group for the Advancement of Psychiatry Committee on Cultural Psychiatry: *Alcoholism in the United States: Racial and Ethnic Considerations*. Washington, DC, American Psychiatric Press, 1996
- Group for the Advancement of Psychiatry Committee on Cultural Psychiatry: *Cultural Assessment in Clinical Psychiatry*. Washington, DC, American Psychiatric Publishing, 2002
- *Hays PA: *Addressing Cultural Complexities in Practice, Assessment, Diagnosis, and Therapy*, 2nd Edition. Washington, DC, American Psychological Association, 2007
- Hays PA, Iwamasa GY (eds): *Culturally Responsive Cognitive-Behavioral Therapy: Assessment, Practice, and Supervision*. Washington, DC, American Psychological Association, 2006
- Hellman R, Drescher J (eds): *Handbook of LGBT Issues in Community Mental Health*. New York, Haworth, 2005
- Helms JE, Cook DA: *Using Race and Culture in Counseling and Psychotherapy: Theory and Process*. Boston, MA, Allyn & Bacon, 1999
- Hinton D, Good B (eds): *Culture and Panic Disorder*. Palo Alto, CA, Stanford University Press, 2009
- Inciawar M, Wintrob R, Bouchard L (eds): *Psychiatrists and Traditional Healers: Unwitting Partners in Global Mental Health*. New York, Wiley, 2009
- Jordan JV: *Relational-Cultural Therapy*. Washington, DC, American Psychological Association, 2007
- Josephson AM, Peteet JR (eds): *Handbook of Spirituality and Worldview in Clinical Practice*. Washington, DC, American Psychiatric Publishing, 2004
- Kim LIC: *Beyond the Battle Line: The Korean War and My Life*. Bloomington, IN, Xlibris, 2012
- Kirmayer LJ, Valaskakis G (eds): *Healing Traditions: The Mental Health of Aboriginal Peoples in Canada*. Vancouver, Canada, University of British Columbia Press, 2009
- Kirmayer LJ, Lemelson R, Barad M (eds): *Understanding Trauma: Integrating Biological, Clinical, and Cultural Perspectives*. New York, Cambridge University Press, 2007
- *Kirmayer LJ, Guzder J, Rousseau C (eds): *Cultural Consultation: Encountering the Other in Mental Health Care*. New York, Springer, 2014

- Kitanaka J: *Depression in Japan: Psychiatric Cures for a Society in Distress*. Princeton, NJ, Princeton University Press, 2011
- *Kleinman A: *Rethinking Psychiatry: From Cultural Category to Personal Experience*. New York, Free Press, 1988
- Kleinman A, Yan Y, Jun J, et al: *Deep China: The Moral Life of the Person*. Berkeley, University of California Press, 2011
- Koenig HG: *Spirituality in Patient Care: Why, How, When, and What*, 3rd Edition. West Conshohocken, PA, Templeton Press, 2013
- Kohen D (ed): *Oxford Textbook of Women and Mental Health*. New York, Oxford University Press, 2010
- Kurasaki K, Okazaki S, Sue S (eds): *Asian American Mental Health: Assessment Theories and Methods*. New York, Plenum, 2002
- Larson D, Lu F, Swyers J (eds): *Model Curriculum for Psychiatry Residency Training Programs: Religion and Spirituality in Clinical Practice*. Rockville, MD, National Institute for Healthcare Research, 1997
- Lee E (ed): *Working With Asian Americans: A Guide for Clinicians*. New York, Guilford, 1997
- Leong FTL (ed): *APA Handbook of Multicultural Psychology*. Washington, DC, American Psychological Association, 2013
- Levounis P, Drescher J, Barber ME (eds): *The LGBT Casebook*. Washington, DC, American Psychiatric Publishing, 2012
- Linde P: *Of Spirits and Madness: An American Psychiatrist in Africa*. New York, McGraw-Hill, 2001
- Lipson JG, Dibble SL (eds): *Culture and Clinical Care*, 2nd Edition. San Francisco, CA, UCSF Nursing Press, 2005
- Lopez A, Carrillo E (eds): *The Latino Psychiatric Patient: Assessment and Treatment*. Washington, DC, American Psychiatric Publishing, 2001
- Lynch EW, Hanson MJ: *Developing Cross-Cultural Competence: A Guide for Working With Children and Their Families*, 4th Edition. Baltimore, MD, Paul H. Brookes, 2011
- Makadon HJ, Mayer KH, Potter J, et al (eds): *The Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health*. Philadelphia, PA, American College of Physicians, 2007
- McDermott JF, Andrade NN (eds): *People and Cultures of Hawai'i: The Evolution of Culture and Ethnicity*, 2nd Edition. Honolulu, University of Hawai'i Press, 2011

- McGoldrick M, Hardy KV (eds): *Re-visioning Family Therapy: Race, Culture, and Gender in Clinical Practice*, 2nd Edition. New York, Guilford, 2008
- *McGoldrick M, Giordano J, Garcia-Prero N (eds): *Ethnicity and Family Therapy*, 3rd Edition. New York, Guilford, 2005
- Mezzich JE, Caracci G (eds): *Cultural Formulation: A Reader for Psychiatric Diagnosis*. Lanham, MD, Jason Aronson, 2008
- Mezzich JE, Kleinman A, Fabrega H, et al (eds): *Culture and Psychiatric Diagnosis: A DSM-IV Perspective*. Washington, DC, American Psychiatric Press, 1996
- *Mollica RF: *Healing Invisible Wounds: Paths to Hope and Recovery in a Violent World*. Boston, MA, Houghton Mifflin Harcourt, 2006
- Nadal K: *Filipino American Psychology: A Handbook of Theory, Research, and Clinical Practice*. New York, Wiley, 2011
- Ng CH, Lin K-M, Singh BS, et al (eds): *Ethno-psychopharmacology: Advances in Current Practice*. New York, Cambridge University Press, 2008
- Norris DM, Jayaram G, Primm AB (eds): *Women in Psychiatry: Personal Perspectives*. Washington, DC, American Psychiatric Publishing, 2012
- Okasha A, Arboleda-Florez J, Sartorius M (eds): *Ethics, Culture and Psychiatry: International Perspectives*. Washington, DC, American Psychiatric Press, 2000
- Okpaku SO (ed): *Clinical Methods in Transcultural Psychiatry*. Washington, DC, American Psychiatric Press, 1998
- O'Neil TD: *Disciplined Hearts: History, Identity and Depression in an American Indian Community*. Berkeley, University of California Press, 1996
- Parekh R (ed): *The Massachusetts General Hospital Textbook on Diversity and Cultural Sensitivity in Mental Health*. New York, Humana Press, 2014
- Pargament K: *Spiritually Integrated Psychotherapy: Understanding and Addressing the Sacred*. New York, Guilford, 2007
- Patel V, Minas H, Cohen A, et al (eds): *Global Mental Health: Principles and Practice*. New York, Oxford University Press, 2013
- Peteet JR: *Depression and the Soul: A Guide to Spiritually Integrated Treatment*. New York, Routledge, 2011
- Peteet JR, D'Ambra MN (eds): *The Soul of Medicine: Spiritual Perspectives and Clinical Practice*. Baltimore, MD, Johns Hopkins University Press, 2011

- Peteet JR, Lu F, Narrow W (eds): *Religious and Spiritual Issues in Psychiatric Diagnosis: A Research Agenda for DSM-V*. Washington, DC, American Psychiatric Publishing, 2010
- Pinderhughes E: *Understanding Race, Ethnicity and Power*. New York, Free Press, 1988
- Richards PS, Bergin AE (eds): *Casebook for A Spiritual Strategy in Counseling and Psychotherapy*. Washington, DC, American Psychological Association, 2003
- Richards PS, Bergin AE: *A Spiritual Strategy for Counseling and Psychotherapy*, 2nd Edition. Washington, DC, American Psychological Association, 2005
- *Richards PS, Bergin AE: *Handbook of Psychotherapy and Religious Diversity*, 2nd Edition. Washington, DC, American Psychological Association, 2014
- Ridley C: *Overcoming Unintentional Racism in Counseling and Therapy*, 2nd Edition. Thousand Oaks, CA, Sage, 2005
- *Ruiz P, Primm A (eds): *Disparities in Psychiatric Care: Clinical and Cross-Cultural Perspectives*. Philadelphia, PA, Lippincott Williams & Wilkins, 2009
- Sanchez-Hucles J: *The First Session With African-Americans: A Step-by-Step Guide*. San Francisco, CA, Jossey-Bass, 1999
- Santiago-Rivera AL, Arrendondo P, Gallardo-Cooper M (eds): *Counseling Latinos and la Familia: A Practical Guide*. Thousand Oaks, CA, Sage, 2001
- Satcher D, Pamies R (eds): *Multicultural Medicine and Health Disparities*. New York, McGraw-Hill, 2006
- Scotton B, Chinen A (eds): *Textbook of Transpersonal Psychiatry and Psychology*. New York, Basic Books, 1996
- Seely KM: *Cultural Psychotherapy: Working With Culture in the Clinical Encounter*. Lanham, MD, Jason Aronson, 2006
- Silverstein C (ed): *The Initial Psychotherapy Interview: A Gay Man Seeks Treatment*. Burlington, MA, Elsevier, 2011
- Singer T, Kimbles SL (eds): *The Cultural Complex: Contemporary Jungian Perspectives on Psyche and Society*. New York, Routledge, 2004
- Smalley KB, Warren J, Rainer J (eds): *Rural Mental Health: Issues, Policies, and Best Practices*. New York, Springer, 2012

- *Smedley BD, Stith AY, Nelson AR (eds): *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC, National Academies Press, 2003
- Smedley BD, Butler AS, Breistow LR (eds): *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*. Washington, DC, National Academies Press, 2004
- Sorel E (ed): *21st Century Global Mental Health*. Burlington, MA, Jones & Bartlett Learning, 2013
- Spurlock J (ed): *Black Psychiatrists and American Psychiatry*. Washington, DC, American Psychiatric Association, 1999
- Straussner S, Ashenberg L: *Ethnocultural Factors in Substance Abuse Treatment*. New York, Guilford, 2001
- Sue DW: *Microaggressions in Everyday Life: Race, Gender, and Sexual Orientation*. New York, Wiley, 2010a
- Sue DW (ed): *Microaggressions and Marginality: Manifestation, Dynamics, and Impact*. New York, Wiley, 2010b
- Sue DW, Sue D: *Counseling the Culturally Diverse: Theory and Practice*, 6th Edition. New York, Wiley, 2012
- Sue DW, Gallardo ME, Neville HA (eds): *Case Studies in Multicultural Counseling and Therapy*. New York, Wiley, 2014
- Trinh N-H, Rho YC, Lu F, et al (eds): *Handbook of Mental Health and Acculturation in Asian American Families*. New York, Humana Press, 2009
- *Tseng W-S: *Handbook of Cultural Psychiatry*. San Diego, CA, Academic Press, 2001
- Tseng W-S: *Clinician's Guide to Cultural Psychiatry*. San Diego, CA, Academic Press, 2003
- Tseng W-S, Streltzer J (eds): *Culture and Psychopathology: A Guide to Clinical Assessment*. New York, Brunner/Mazel, 1997
- Tseng W-S, Streltzer J (eds): *Culture and Psychotherapy: A Guide to Clinical Practice*. Washington, DC, American Psychiatric Press, 2001
- Tseng W-S, Streltzer J (eds): *Cultural Competence in Clinical Psychiatry*. Washington, DC, American Psychiatric Publishing, 2004
- Tseng W-S, Matthews D, Elwyn T: *Cultural Competence in Forensic Mental Health*. New York, Taylor & Francis, 2004

- Tseng W-S, Chang SC, Nishizono M (eds): *Asian Culture and Psychotherapy: Implications for East and West*. Honolulu, University of Hawai'i Press, 2005
- *U.S. Department of Health and Human Services: *Mental Health: Culture, Race, and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD, U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General, 2001
- Verhagen P, Van Praag HM, Lopez-Ibor JJ, et al (eds): *Religion and Psychiatry: Beyond Boundaries*. New York, Wiley, 2010
- Walsh F (ed): *Spiritual Resources in Family Therapy*, 2nd Edition. New York, Guilford, 2009
- Weinreich P, Saunderson W (eds): *Analyzing Identity: Cross-Cultural, Societal and Clinical Contexts*. New York, Routledge, 2002
- Young-Bruehl E: *The Anatomy of Prejudices*. Cambridge, MA, Harvard University Press, 1996

Journals

Three major journals focus on cultural psychiatry:

- *Cultural Diversity & Ethnic Minority Psychology* (American Psychological Association)
- *Culture, Medicine, and Psychiatry* (Springer)
- *Transcultural Psychiatry* (Sage)

Other journals of interest include the following:

- *International Journal of Culture and Mental Health* (Taylor & Francis)
- *World Cultural Psychiatry Research Review* (online), <http://www.wcpr.org>

Web Sites

American Academy of Child and Adolescent Psychiatry Practice Parameter for Cultural Competence in Child and Adolescent Psychiatric Practice (2013): https://www.aacap.org/App_Themes/AACAP/docs/practice_parameters/Cultural_Competence_Web.pdf

American Medical Association, Minority Affairs Section: <http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/minority-affairs-section.page?>

American Psychiatric Association Division of Diversity and Health Equity (including residency training curriculum materials): <http://www.psychiatry.org/practice/professional-interests/diversity>

American Psychological Association, Office of Ethnic Minority Affairs: <http://www.apa.org/pi/oema/index.aspx>

Association of American Medical Colleges

- Diversity and Inclusion: <https://www.aamc.org/initiatives/diversity/>
- Group on Diversity and Inclusion: <https://www.aamc.org/members/gdi>
- Tool for Assessing Cultural Competence Training (TACCT): <https://www.aamc.org/initiatives/tacct/>

Group for the Advancement of Psychiatry LGBT Committee Mental Health Syllabus: <http://download.journals.elsevierhealth.com/pdfs/journals/0890-8567/PIIS089085671200500X.pdf>

The Joint Commission

- Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals (2010): <http://www.jointcommission.org/assets/1/6/aroamapforhospitalsfinalversion727.pdf>
- Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide (2011): http://www.jointcommission.org/assets/1/18/LGBTFieldGuide_WEB_LINKED_VER.pdf

Liaison Committee on Medical Education (LCME) accreditation standards for medical schools: <https://www.lcme.org/publications.htm>

- ED-19 on teaching communication skills with patients, families, colleagues and other health professionals
- ED-21 on teaching cultural competence skills in the curriculum and to students to be evaluated
- ED-22 on addressing gender and cultural biases in medical students, in others, and in the health care system and teaching about demographic influences on health care quality and disparities in health care delivery
- IS-16 on institutional policies and practices to achieve diversity among students, faculty, and staff

- MS-8 on broadening the diversity of medical school applicants
 - MS-9 on admission, retention, and graduation of students with disabilities
 - MS-31 on no discrimination on the basis of age, creed, gender identity, national origin, race, sex, or sexual orientation
- McGill University, Division of Social and Transcultural Psychiatry: <http://www.mcgill.ca/tcpsych>
- National Health Law Program, language access: <http://www.healthlaw.org/issues/health-disparities/language-access>
- New York State Office of Mental Health
- Bureau of Cultural Competence: https://www.omh.ny.gov/omhweb/cultural_competence/
 - Nathan Kline Institute Center of Excellence in Culturally Competent Mental Health: <http://ssrdqst.rfmh.org/cecc/>
 - New York State Psychiatric Institute Center of Excellence for Cultural Competence: <http://nyspi.org/culturalcompetence/>
- Society for the Study of Psychiatry and Culture: <http://www.psychiatryandculture.org>
- U.S. Department of Health and Human Services
- Agency for Healthcare Research and Quality (AHRQ) Innovations Exchange: <http://innovations.ahrq.gov/index.aspx>
 - AHRQ National Healthcare Quality & Disparities Reports: <http://www.ahrq.gov/research/findings/nhqrd/index.html>
 - Enhancing the Delivery of Health Care: Eliminating Health Disparities through a Culturally & Linguistically Centered Integrated Health Care Approach (2013): <http://www.hogg.utexas.edu/uploads/documents/FinalReport%20ConsensusStatementsRecommendations.pdf>
 - Health Resources and Services Administration (HRSA) on culture, language, and health literacy: <http://www.hrsa.gov/culturalcompetence/index.html>
 - Integrated Care for Asian American, Native Hawaiian and Pacific Islander Communities: A Blueprint for Action (2012): http://www.integration.samhsa.gov/workforce/Integrated_Care_for_AANHPI_Communities_1_23_12_Blue_II.pdf
 - National CLAS Standards: <https://www.thinkculturalhealth.hhs.gov/>
 - National Institute on Minority Health and Health Disparities: <http://www.nimhd.nih.gov/>

- Office of Minority Health (OMH): <http://minorityhealth.hhs.gov/>
 - Pathways to Integrated Health Care: Strategies for African American Communities and Organizations (2011): <http://minorityhealth.hhs.gov/Assets/pdf/Checked/1/PathwaystoIntegratedHealthCareStrategiesforAfricanAmericans.pdf>
 - Substance Abuse and Mental Health Administration (SAMHSA) Resource Center to Promote Acceptance, Dignity and Social Inclusion Associated with Mental Health (ADS Center): <http://promoteacceptance.samhsa.gov/default.aspx>
- World Association of Cultural Psychiatry: <http://www.waculturalpsy.org>
- World Psychiatric Association, Transcultural Psychiatry Section: <http://www.wpa-tps.org>

Index

Page numbers printed in *boldface* type refer to figures or tables.

- AACP. *See* American Academy of Child and Adolescent Psychiatry
- AAP. *See* American Academy of Pediatrics
- Accreditation Council for Graduate Medical Education (ACGME), 412
- Acculturation
- African Americans and, 97
 - Asian Americans and, 151
 - assessment of cultural identity and, 55–56
 - case example of assessment of, 16–17
 - cultural identity and definition of, 14, 16
 - Hispanic Americans and, 224
- Adherence
- Asian American patients and, 173
 - cultural explanations for noncompliance and, 73
 - ethnopsychopharmacology and, 450, 460
- Adinazolam, 442
- Adolescents. *See also* Age; Children
- Cultural Formulation Interview and, 509–512
 - delinquency and Asian American, 167
 - developmental issues for Asian American, 151
 - development of sexual identity in, 366, 367–368
 - disclosure of sexual orientation to providers by LGBT, 343
 - issues in mental health care for LGBT, 376–377, 385, 386
 - suicide rates in Hispanic American, 220
 - transgender identity formation in, 400
 - women's life cycles and, 317–318
- Affect. *See also* Emotional stability
- assessment of in Hispanic Americans, 235
 - gender issues in mental status examination and, 309
- Affiliation, cultural identity and degree of, 14
- Afghanistan, 318
- Africa
- culture-bound syndromes in, 64, 523–524

Africa (*continued*)

- magico-spiritual practices and diaspora from, 100–101

African Americans

- case example of cultural formulation for, 539–542

- cultural conceptualizations of distress in, 100–102, 114, 540–541

- cultural features of patient-clinician relationship and, 106–110, 112–114, 541

- cultural identity and, 93–102, 540

- disclosure of sexual orientation to providers and, 343

- diversity of, 77–78

- ethnopsychopharmacology and, 89, 92, 438, 439, 441, 442, 443, 449, 451, 452, 453, 460

- family structure and, 81

- historical context of, 79–80

- mental health status and use of services by, 83–92

- misdiagnosis of schizophrenia in, 6, 85, 116–117

- overall cultural assessment and, 111, 114–117, 542

- physical status of, 82–83

- population of U.S. and, 2

- psychosocial stressors and cultural features of vulnerability and resilience in, 103–106, 541

- roles of religion and spirituality among women, 422, 424

- socioeconomic status of, 81–82

- use of OCF for, 92–117

- Afrocentrism, 93, 97

- Age, and cultural identity, 52. *See also* Adolescents; Age at onset; Aging; Children; Elderly

- Age at onset, of schizophrenia, 306

- Aggression, and patient-clinician relationship, 26

- Aging, and life cycles of women, 320–321. *See also* Elderly

- Agranulocytosis, and clozapine, 441

- A HOLY (mnemonic), 66

- AIAN (American Indian or Alaska Native). *See* Alaska Natives; Native Americans

AIDS

- African Americans and, 83
- religion and spirituality in men diagnosed with, 424–425
- sexual orientation and, 343, 345, 377

- Alaska Natives. *See also* Native Americans

- characteristics of healers and, 274–275

- communal identity of, 261–262

- culture-bound syndromes and, 65
- use of term, 253

- Albania, 397

- Alcoholics Anonymous, 406

- Alcohol use and alcoholism. *See also* Substance use disorders

- Asian Americans and, 167

- Native Americans and, 258

- transgender identity and, 406, 408

- Algonkian, and culture-bound syndromes, 65

- Alienation, and Asian American adolescents, 151

- Alprazolam, 442

- Ambivalence
 cultural conflicts in patient-clinician
 relationship and, 27
 frequency of in ethnic minority
 patients, 474
- American Academy of Child and
 Adolescent Psychiatry (AACAP),
 354, 561
- American Academy of Pediatrics
 (AAP), 354
- American Indians, use of term, 253. *See*
 also Native Americans
- American Medical Association, 354,
 562
- Americanos*, use of term, 198
- American Psychiatric Association
 (APA), 303, 354, 355–356, 412,
 427, 562
- American Psychological Association,
 354, 356, 562
- Amok*, 61, 142
- Anger, and patient-clinician
 relationship, 27
- Animism, 146, 148
- Anorexia nervosa, 63
- Antibiotics, 444
- Anticholinergic psychosis, and herbal
 medications, 139
- Antidepressants, and ethnopsychopharmacology, 437–439, 444,
 445, 446, 449, 450. *See also*
 Selective serotonin reuptake
 inhibitors; Tricyclic
 antidepressants
- Antipsychotics, and ethnopsychopharmacology, 439–442, 444,
 445, 446, 449. *See also* Atypical
 antipsychotics; Neuroleptics
- Anti-Semitism, 327
- Antisocial behavior, and Hispanic
 Americans, 236
- Anxiety disorders. *See also* Social
 anxiety disorder
 in African Americans, 85
 in Asian Americans, 140
 increased risk of in lesbian, gay, and
 bisexual individuals,
 348
- APA. *See* American Psychiatric
 Association
- Appalachia, and culture-bound
 syndromes, 527
- Arabs, and ethnopsychopharmacology,
 450
- Argentina, 195
- Ashaktapanna*, 529
- Asian Americans. *See also* Chinese
 Americans; Filipino Americans;
 South Asian Americans; Southeast
 Asian Americans
 case examples of cultural formation
 for, 535–539, 542–545
 cultural conceptualizations of
 distress and, 139–147, 536–
 537, 543
 cultural identity of, 135–139, 536,
 542–543
 ethnic diversity of, 127–128
 ethnopsychopharmacology and,
 154–155, 156, 159, 165–166,
 438, 439, 440, 441–442, 443,
 449, 451, 453, 454, 459–460
 growth in population of, 127, 128,
 129
 immigration patterns of, 128, 130–
 133
 mental health of lesbian, gay, or
 bisexual, 347

Asian Americans (*continued*)

- overall cultural assessment and, 171–174, 538–539
 - patient–clinician relationship and, 154–169, 538, 544–545
 - as percentage of U.S. population, 1, 2
 - psychosocial stressors and cultural features of vulnerability and resilience for, 147, 149–154, 537–538, 544
 - use of mental health services by, **90–91**
 - use of OCF for, 134–174
- Assessment. *See also* Cultural Formulation Interview; Outline for Cultural Formulation; Overall cultural assessment
- of acculturation, 16–17
 - gender issues in, **292–302, 308–315, 332–333**
 - Hispanic Americans and tools for, 237–238
 - performance of spiritual, 413–417
 - women and clinical, 306–307
- Assimilation
- African Americans and, 97
 - levels of acculturation and, 14
- Association of American Medical Colleges, 562
- Ataque de nervios*, **62**, 519–520. *See also Nervios*
- Attention-deficit/hyperactivity disorder (ADHD), 222, 236
- Atypical antipsychotics, 440–441, **443**
- Authority
- Asian Americans and view of in patient–clinician relationship, 169

- gender roles in Hispanic American culture and, 202
- Autoracism, 26–27
- Ayurveda, 147, **148**, 521
- Balseros* (“rafters”), 191
- BATHE, as mnemonic for cultural formulation, 47
- Beck Depression Inventory, 238
- Belize, 193
- Benzodiazepines, and ethnopsychopharmacology, 442, 445, 450
- Bilis*, **62**, 213
- Biological approach, to treatment for Asian Americans, 157
- Bipolar disorder, 408
- Blacking out, as culture-bound syndrome, 520
- Black Pain* (Williams 2008), 104
- Boarding schools, and Native American experience, 256–257
- Body dysmorphic disorder, 532
- Body image, and gender issues in cultural assessment, 295
- Bouffée délirante*, **64**, 102
- Brain fog, as culture-bound syndrome, **64**, 102, 524, 529
- Brazil, 195
- Brief Psychiatric Rating Scale, 238
- Brief Symptom Inventory, 238
- Brujería*, 205
- Buddhism, 136, 144–145. *See also* Zen Buddhism
- Bulimia nervosa, 86
- Bullying, effect of on sexual minorities, 374–375
- Burnout syndrome, as culture-bound syndrome, 529

-
- Calcium channel blockers, 444
 - California, and LGBT issues in
 - curriculum of public schools, 342
 - Cambodia, and Cambodian Americans, 132, 135, 165, 522. *See also* Hmong
 - Canada. *See also* Canadian Psychiatric Association
 - nerves* as culture-bound syndrome in Newfoundland, 527
 - studies of spirituality and religiousness in patients, 414, 427
 - Canadian Psychiatric Association, 291, 303
 - Caregivers, and Cultural Formulation Interview, 516–517
 - Caribbean
 - culture-bound syndromes in, 64, 524
 - ethnopsychopharmacology in Afro-Caribbean patients, 441
 - Hispanic Americans from, 189–193
 - origins of African Americans and, 78, 83
 - Case examples
 - of application of OCF for cultural issues of women, 321–323
 - of assessment of acculturation, 16–17
 - of cultural conceptualizations of distress
 - in African Americans, 100–101, 540–541
 - in Asian Americans, 141, 543
 - in Euro American patient, 550
 - in Hispanic Americans, 59–60, 215–216, 547
 - in Native Americans, 266
 - in Vietnamese American patient, 536–537
 - of cultural formulation
 - in African American patient, 539–542
 - in Asian American patient, 542–549
 - in Euro American patient, 549–552
 - in Hispanic American patient, 546–549
 - in Vietnamese American patient, 535–539
 - of cultural identity
 - in African Americans, 95, 96–97, 98, 540
 - in Asian Americans, 137–138, 542–543
 - in Euro American patient, 549–550
 - in Hispanic Americans, 199–200, 546–547
 - in lesbian, gay, bisexual, and transgender people, 370, 372
 - in Native Americans, 260
 - in Vietnamese American patient, 536
 - of development of sexual identity, 366–367
 - of disclosure of sexual orientation, 346
 - of effects of bullying on sexual minorities, 374–375
 - of lesbian, gay, and bisexual individuals as elderly, 387
 - of overall cultural assessment
 - African Americans and, 111, 114, 115–116, 542

Case examples (*continued*)

of overall cultural assessment

(*continued*)Asian Americans and, 171–172,
174, 545

Euro American patient and, 552

Hispanic Americans and, 548–
549

Native Americans and, 277

Vietnamese American patient
and, 538–539

of patient-clinician relationship

African Americans and, 110, 541

Asian Americans and, 156, 160–
161, 163, 164, 170, 544–
545Euro American patient and,
551–552Hispanic Americans and, 226–
227, 230–231, 548lesbian, gay, bisexual, and
transgender individuals
and, 371, 373

Native Americans and, 273

Vietnamese American patient
and, 538

of practical use of OCF in clinical

practice, 9, 11–14, 16–19, 22,
24, 28, 35–36

of psychosocial stressors and

vulnerability/resilience factors

in African Americans, 104, 541

in Asian Americans, 544

Euro American patient and, 551

in Hispanic Americans, 221–
222, 547–548in lesbian, gay, bisexual, and
transgender individuals,
370–371, 372

in Native Americans, 271

in Vietnamese American patient,
537–538of spiritual assessment, 413–414,
416–417of transgender patients in health
care settings, 404–405

Castration anxiety, 353

Catholicism, and Catholic Church,
204, 350–351*Celaje*, 212

Center for Epidemiologic Studies

Depression Scale (CES-D), 268–
269, 305Central Americans. *See* Hispanic
AmericansCFI. *See* Cultural Formulation
Interview

Charcot, Jean-Martin, 352

Chemotherapy, 444

Chest surgery, and transgender care,
398, 401*Chicano* cultural identity, 197, 224Children, and childhood. *See also*Adolescents; Development; Infant
mortality; Parents and parentingcare of and gender issues in
culturally competent
assessment, 296Cultural Formulation Interview
and, 509–512

gender identity and, 359

life cycles of women and, 307, 316–
317Native American experience and
boarding schools, 257Native Americans and
intergenerational relationships,
272

-
- religious beliefs and, 67
transgender identity formation in,
399–400
- Chile, 195
- China
culture-bound syndromes in, 61,
142, 143, 521, 528–529
gender issues in, 318, 319
political repression and immigration
to U.S. from, 130
suicide rate in, 305
- Chinese Americans. *See also* Asian
Americans
community support organizations
and, 165
cultural identity of subgroups of,
135
cultural identity of women and,
324, 325, 326
ethnopsychopharmacology and,
441, 442, 454
history of, 130–131
population of, 129
- Chinese Classification of Mental
Disorders* (CCMD-2-R), 528
- Chinese Exclusion Act of 1882, 130
- Chromosomal identity, 358
- Chronic fatigue syndrome, 529
- Cibih*, 531
- Cigarette smoking
African Americans and, 86
ethnopsychopharmacology and,
452, 453, 455, 461
- Circular migration, and Hispanic
Americans, 189
- Civil rights
of African Americans, 79
of LGBT people, 355, 356
- Civil Rights Act of 1964, 79
- Clark, Kenneth and Mamie, 97
- Clergy, as mental health counselors,
421–422
- Clinical anthropologist syndrome, 26
- Clinical Antipsychotic Trials of
Intervention Effectiveness
(CATIE), 452
- Clinicians. *See* Cultural features of
relationship between individual
and clinician
- Clothing, and gender-based cultural
practices, 318. *See also* Personal
appearance
- Clozapine, 441, 442, 443
- Cochrane Handbook for Systematic
Reviews of Interventions* (Higgins
and Green 2011), 348
- Cognitive-behavioral therapy (CBT),
161–162
- Coining, and traditional medicine, 146,
148
- Cólera*, 213
- Collaborative model, for conflicts in
explanatory models of distress, 20
- Collective efficacy, of African American
communities, 82
- Colombia, 195, 438
- Communication. *See also* Language;
Nonverbal communication
African Americans and physician-
patient, 92, 108
Asian Americans and styles of, 137,
157–158
- Community. *See also* Social system
assessment of cultural related
strengths or supports and, 62–
63, 67–68
collective efficacy of African
American, 82

Community (*continued*)

- social support for Asian American patients and, 165

Compadrazgo, 199

Complete Idiot's Guide to Native

- American History, The* (Fleming 2003), 255

Compliance. *See* Adherence

Confidentiality, and professional interpreters, 33

Conflicts

- Asian American families and, 166–168

- Asian Americans and intergenerational, 150, 166

- cultural between provider and patient, 25–28

- in explanatory models of distress, 20
- spiritual or religious identity and, 418–419

Confucianism, 136, 141, 143, 144

Constitution (U.S.), and civil rights, 79

Contextualized identities, 12–13

Contraception, and life cycles of women, 319

Conversion disorder, 519

Coping

- African Americans and, 106

- religion and spirituality in strategies of, 422–424

- supplementary module of Cultural Formulation Interview and, 505–507

Cosmetic surgeries, in Westernized cultures, 318

Cost, and access to mental health care, 87

Costa Rica, 193, 194

Countertransference

- Asian American patients and, 169
- cultural conflicts between clinician and patient, 25, 26, 27

- interethnic and intraethnic issues in patient-clinician relationship and, 69

- women and, 328

Criminal justice system

- African Americans and, 82, 94

- Hispanic Americans and, 220

Cuban Americans, 190–192. *See also* Hispanic Americans

Cuento therapy, 239

Cultural brokers

- Hispanic American patients and, 214

- interpreters as, 33

- overall cultural assessment and, 72

- patient-clinician relationship and, 70

- religious or spiritual brokers and, 428

- role of in cultural assessment, 34, 474

Cultural conceptualizations of distress.

- See also* Culture-bound syndromes

- African Americans and, 100–102, 114, 540–541

- Asian Americans and, 139–147, 536–537, 543

- application of OCF to standard psychiatric evaluation and, 56–60

Cultural Formulation Interview

- and, 23–24, 57, 59, 102, 209, 494–496

- Euro American patient and, 550

- Hispanic Americans and, 207–217, 547
- Native Americans and, 266–271
- OCF framework for assessment and, 478
- overview of assessment of in clinical practice, 19–24
- religion and spirituality as factors in, 421–422
- summary of general themes of OCF and, 471
- transgender patients and, 406
- women and, 325–326
- Cultural congruence, and mental health care for Hispanic Americans, 214–217
- Cultural features of relationship
 between individual and clinician.
 See also Countertransference;
 Therapeutic alliance; Transference
- African Americans and, 106–110, 112–114, 541
- application of OCF to standard psychiatric evaluation, 68–71
- Asian Americans and, 154–169, 538, 544–545
- Cultural Formulation Interview
 and, 507–509
- cultural issues for women and, 328–329
- ethnopsychopharmacology and, 460
- Euro American patient and, 551–552
- Hispanic Americans and, 223–233, 548
- lesbian, gay, and bisexual
 individuals and, 371, 373
- Native Americans and, 273–277, 278, 279
- OCF framework for assessment and, 478
- overview of issues in clinical practice, 25–34
- religion and spirituality, 425–428
- summary of general themes of OCF and, 472–473
- transgender identity and, 407–408
- Cultural Formulation Interview (CFI)
 components and supplementary
 modules of, 10–11, 134, 253, 473–474, 480–481, 481–486, 493–517
- cultural concepts of distress and, 23–24, 57, 59, 102, 209, 269
- cultural identity and, 51, 95, 139, 200–201, 206–207, 262, 263, 402
- informant version of, 487–492
- introduction to, 7
- language assessment and, 48–49
- LGBT patients and, 382–383, 384–385
- migration history and, 55
- patient–clinician relationship and, 28, 71, 110, 277
- psychosocial stressors and, 25, 66, 103, 219–220
- religious/spiritual beliefs and, 52–53, 96–97
- sexual orientation and, 50, 265
- structure and use of, 479–480
- support systems and, 66, 103, 272–273
- women and, 331–332

- Cultural identity
- of African Americans, 93–99, 540
 - of Asian Americans, 135–139, 536, 542–543
 - application of OCF to standard psychiatric evaluation and, 46, 48–56
 - Cultural Formulation Interview and, 51, 95, 139, 200–201, 206–207, 502–505
 - definition of and basic concepts in, 9, 11
 - of Euro-American patient, 549–550
 - facets of, 13
 - of Hispanic Americans, 196–207, 546–547
 - of lesbian, gay, and bisexual individuals, 359–375, 379–381
 - of Native Americans, 260–266
 - OCF framework for assessment and, 477–478
 - of patient compared to clinician, 68
 - overview of assessment of in clinical practice, 11–14, 16–19
 - religion and spirituality, 18, 52, 324–325, 327, 418–420
 - summary of general themes in OCF and, 470–471, 474
 - transgender patients and, 402, 405–406
 - women and, 323–325
- Cultural informants. *See* Cultural brokers
- Cultural interpretation, 33
- Cultural myopia, 27
- Cultural reference groups, and Native Americans, 260–262
- Cultural relaxation techniques, and Asian Americans, 162
- Culture
- conceptual distinction between ethnicity and, 12
 - definition of in Cultural Formulation Interview, 479
 - essential components of, 5
 - ethnopsychopharmacology and, 459–460
- Culture-bound syndromes. *See also* Cultural conceptualizations of distress
- African Americans and, 102
 - in Africa, 64
 - in Asia, 61
 - Asian Americans and, 140–141, 142–143
 - in Caribbean, 64, 520, 524
 - cultural concepts of distress in DSM-5 and, 23, 519–533
 - Hispanic Americans and, 209–213
 - industrialized countries, 63
 - in Latin America, 62
 - in Native Americans, 65, 267
- Culture-related diagnostic issues, in DSM-5, 19
- Cupping, and traditional medicine, 146, 148
- Curanderos* and *curanderismo*, 205
- Cytochrome P450 enzymes, and ethnopsychopharmacology, 165, 436, 437, 442, 444, 445, 446–447, 448–457, 458
- Dark Girls* (film), 97
- Death. *See also* Mortality
- LGBT people and preparation for, 379

- women and cultural rituals of, 321
- Defense of Marriage Act (DOMA), 356
- Demographic information, use of
Cultural Formulation Interview in
conjunction with, 479–480
- Denial, of cultural and ethnicity, 26
- Dependency-related behaviors, and
developmental issues for Hispanic
Americans, 201
- Depression. *See also* Postpartum
depression
in African Americans, 84, 87–88, 105
in Asian Americans, 140
gender differences in, 305
in lesbian, gay, and bisexual
individuals, 348
misdiagnosis of in ethnic minorities,
437
in Native Americans, 269
in Puerto Ricans, 218
religious or spiritual commitment
and, 420
- Desipramine, 448
- Development. *See also* Children
gender issues in assessment and, 312
issues of for Asian Americans, 150–
152
issues of for Hispanic Americans,
201–202, 220
Native Americans and cultural
factors in, 263–264
of sexual identity, 362–368
women's life cycles and, 307, 316–
321
- Dhat* syndrome, 61, 142, 521–522
- Diabetes, 460
- Diagnosis. *See* Assessment; Differential
diagnosis; Misdiagnosis
- Diazepam, 442, 454
- Dichos* (sayings), 225, 239
- Dietary practices, and environmental
factors in psychopharmacology,
455, 456, 458, 459, 461
- Differential diagnosis, and overall
cultural assessment, 72
- Dignidad* (self-dignity), 233
- Digoxin, 457, 458
- Diné, 261
- Disability, Native Americans and levels
of, 272. *See also* Functioning
- Dissociative disorders, 519
- Distancing, and patient-clinician
relationship, 27
- Distress. *See* Cultural
conceptualizations of distress;
Functioning
- Domestic violence
Asian American families and, 166–
167
assessment of culturally related
strengths or supports and, 63–
64
cultural issues for women and, 327
gender issues for Asian Americans
and, 153
religious values and, 422, 424
- Dominican Americans, 192–193. *See
also* Hispanic Americans
- Drapetomania, 79
- Drug-drug interactions, and
ethnopsychopharmacology, 448
- DSM-I, and homosexuality, 355
- DSM-II, and homosexuality, 355
- DSM-III-R, and homosexuality, 355–
356
- DSM-IV, and culture, 3–4
- DSM-IV-TR
gender identity disorder in, 399

DSM-IV-TR (*continued*)

- histrionic personality disorder in, 288
 - Outline for Cultural Formulation in, 8
- DSM-5. *See also* Cultural Formulation Interview; Outline for Cultural Formulation
- culture-bound syndromes in, 23, 519–533
 - culture-related diagnostic issues in, 19
 - gender dysphoria in, 399, 400
 - histrionic personality disorder in, 289
 - increasing sensitivity to cultural variations in, 412
- Duloxetine, 439
- “Duppies” (culture-bound syndrome), 100
- Eastern Europeans, immigration from and possible trauma in, 14
- Eating disorders
- African Americans and, 86
 - as culture-bound syndromes, 63
- Ecograms and ecomaps, and spirituality of Native Americans, 268
- Ecostructural family therapy approach, for Hispanic American patients, 238–239
- Ecuador, 195
- Education. *See also* Medical schools
- Asian Americans and, 149
 - assessment of cultural identity and, 53
 - gender issues in culturally competent assessment and, 292

- Hispanic Americans and levels of, 185, 186
 - HIV and need for continued, 345
 - LGBT issues in curriculum of public, 342
 - mental status examination and levels of, 29
 - Native Americans and, 256–257
- Ego, and internalized homophobia, 362
- Elderly. *See also* Aging
- Asian Americans and, 152
 - Cultural Formulation Interview and, 512–514
 - Hispanic Americans and, 202
 - LGBT individuals and, 378–379, 386–387
- Ellis, Havelock, 353
- El Salvador, 193–194
- Emotional stability, and women, 288, 289. *See also* Affect
- Empacho*, 62
- Empirically based psychosocial interventions, 238–239
- Empty-nest syndrome, 320
- End-of-life issues, for women, 321
- Enlightenment (Age of), and history of homosexuality, 351–352
- Environmental factors, in ethnopsychopharmacology, 454–457
- Epidemiology. *See also* Prevalence
- gender differences in psychopathology and, 305–306
 - of homosexuality, 343–346
- Ericksonian hypnotic framework, 161
- Eskimo, and culture-bound syndromes, 65
- Espanto*, 531

- Espiritismo*, 100, 205–206, 234
- Ethiopia, 450
- ETHNIC, as mnemonic for cultural formulation, 47
- Ethnic identity. *See also* Ethnicity
- Asian Americans and definition of, 135
 - dual minority identity of lesbian, gay, and bisexual individuals and, 371–373, 376
 - as facet of cultural identity, 11
- Ethnicity. *See also* Ethnic identity;
- Ethnic psychopharmacology
 - assessment of cultural identity and, 50–51
 - conceptual distinction between culture and, 12
 - definition of, 5
 - disparities in mental health care of minorities, 2
 - increase in diversity of U.S. population and, 1–2, 127
 - psychopharmacology and variation in medication response by, 437–442
 - subgroups and languages of Asian Americans, 127–128
 - suicide rates in sexual minorities and, 347
 - use of mental health services by, 90–91
- Ethnicity and Family Therapy* (McGoldrick et al. 2005), 70, 474
- Ethnic psychopharmacology, 165–166
- Euro Americans, and case example of cultural formulation, 549–552.
- See also* Eastern Europeans
- Evil, use of term by African Americans, 101
- “Evil eye,” as culture-bound syndrome, 526
- Explanatory models. *See* Cultural conceptualizations of distress
- Extensive metabolizers (EMs), 448
- Extrapyramidal symptoms (EPS), and ethnopsychopharmacology, 442
- Extrinsic orientation, of religion, 66
- Eye contact
- African Americans and, 109
 - Asian Americans and, 158–159
- Falling out, as culture-bound syndrome, 64, 102, 520
- Familismo*, 198–199
- Family. *See also* Grandparents;
- Marriage; Parents and parenting
 - African Americans and structure of, 81, 103
 - Asian Americans and structure of, 149–150
 - assessment of cultural related strengths and supports and, 62, 64–65
 - conflicts in Asian American, 166–168
 - ethnopsychopharmacology and, 461
 - gender roles in, 316–317
 - Hispanic Americans and structure of, 198–201
 - involvement of in treatment of Asian American patients, 165
 - members of as interpreters, 33, 45
 - Native Americans and, 257, 272
 - psychosocial stressors for women and, 326–327
 - relationships of LGBT people with, 377, 383, 385–386

- Family therapy, for Hispanic American patients, 238–239
- Fan nao*, 528
- Female circumcision (female genital mutilation), 317
- Feminism, and history of women's movement, 289–291
- Fertility, and gender issues in culturally competent assessment, 294
- FICA, as religious/spiritual screening tool, 52, 415, 416
- Fiji, 133
- Filipino Americans, 129, 131. *See also* Philippines
- First Nations, use of term, 253. *See also* Native Americans
- Flash of the Spirit* (Thompson 1984), 99
- Fluoxetine, 439
- Food supplements, and
ethnopsychopharmacology, 457, 458, 459
- Freud, Sigmund, 353–354
- Fright illness, as culture-bound syndrome, 64
- Functioning, levels of
Cultural Formulation Interview and, 496
Native Americans and, 272
- Gagá*, 205
- Gambling, and Asian Americans, 168
- Gangs, and Asian American adolescents, 167
- Gender. *See also* Gender identity; Women
epidemiology and differences in psychopathology by, 305–306
interaction of sexuality with, 403
issues of in Asian American cultures, 152–153
issues of in culturally competent assessment, 292–302, 308–315, 332–333
medical school applicants and students by, 291
Native Americans and concepts of, 265, 397
roles and relations of in Hispanic American culture, 202–204, 236
of therapist and cultural issues for women, 328
- Gender dysphoria, 399, 400, 401, 408
- Gender identity. *See also* Gender; Gender identity disorder; Transgender identity
assessment of cultural identity and, 17–18
sexual identity terminology and, 358–359
- Gender identity disorder (GID), 399
- Gender and Its Effects of Psychopathology* (Frank 2000), 291
- Genetics, and ethnopsychopharmacology, 165, 436, 437, 442, 444, 445, 446–447, 448–454, 457, 461
- Genital surgery, and transgender identity, 398, 401–402, 408. *See also* Female circumcision
- Genograms, Native Americans and spiritual, 268
- Gentlemen's Agreement Act, 131
- Germany, and culture-bound syndromes, 63
- Ghost sickness, as culture-bound syndrome, 65, 267

- Gilligan, Carol, 316
- Glass ceiling, and gender issues, 291, 303
- Globalization, and gender issues, 303
- Gold, Judith, 291, 303
- Grandparents
 Hispanic American family and, 199
 life cycles of women and, 321
- Grapefruit juice, and ethnopsychopharmacology, 450, 455, 458
- Greece, 350, 527
- Grisi siknis*, 62
- Group for the Advancement of
 Psychiatry LGBT Committee
 Mental Health Syllabus, 562
- Group therapy, for Asian American patients, 164
- Guatemala, 193–194
- Guilt, and patient-clinician relationship, 26, 27
- Guzmán, Alonso Díaz Ramírez de, 397
- Haiti, and culture-bound syndromes, 64, 520, 525
- Haloperidol, 439, 440
- Harvard Trauma Questionnaire, 29
- Hawaii, 132, 133, 147, 357
- Health care, and health care system. *See also* Health insurance; Herbal medicine; Medicalization; Medical schools; Mental health care; Traditional healing
 African Americans and, 83
 Hispanic Americans and, 207–209
 influence of religion on, 421
 lesbian, gay, and bisexual individuals and, 340–342, 383
 transgender patients and, 402–405
- Health insurance
 African Americans and, 87
 Hispanic Americans and, 187
- Healthy paranoia effect, and African Americans, 108
- Help seeking. *See also* Mental health care; Treatment
 African Americans and, 88–89
 Hispanic Americans and, 213–217
 Native Americans and, 270–271
 religion and spirituality as influences on, 421–422
 supplementary modules of Cultural Formulation Interview and, 505–507
- Herbal medicine. *See also* Traditional healing
 Asian Americans and, 139, 171
 ethnopsychopharmacology and, 450, 455–457, 458, 459
 Native Americans and, 274
- Herman, Judith, 289–290
- Hierarchy, and Asian Americans, 137, 149
- Hijiras*, 397
- Hinduism, 136, 147
- Hippocrates, 288
- Hirschfield, Magnus, 353
- Hispanic Americans. *See also* Caribbean; Cuban Americans; Dominican Americans; Mexican Americans; South America
 case example of cultural formulation for, 546–549
 cultural conceptualizations of distress and, 62, 207–217, 527, 530, 547

Hispanic Americans (*continued*)

- cultural identity of, 196–207, 546–547
 - educational levels of, 185, 186
 - ethnopsychopharmacology and, 438, 440, 441–442, 443
 - history of, 187
 - mental health of lesbian, gay, or bisexual, 347
 - overall cultural assessment and, 233–239, 548
 - patient–clinician relationship and, 223–233, 548
 - as percentage of U.S. population, 1, 2, 78, 184, 185
 - psychosocial stressors and cultural features of vulnerability and resilience for, 217–222, 547–548
 - socioeconomic status of, 185, 186, 187
 - use of mental health services by, 90–91
 - use of OCF for, 196–240
 - use of term Latino and, 183–184, 198
- History. *See also* Migration history
- of African Americans, 79–80, 83
 - of Asian Americans, 130–133
 - of Hispanic Americans, 187–188
 - of LGBT people, 349–358
 - of literature on cultural psychiatry, 3–4
 - of Native Americans, 255–258
 - of women’s mental health and women’s movement, 288–291, 303–304
- Histrionic personality disorder, 288–289

HIV. *See* AIDS

Hi-wa itck, 65

Hmong, 135, 136, 320

HoChunk, 261

Homicidal ideation, and mental status examination, 311

Homophobia, 347, 374, 386. *See also* Internalized homophobia

Homosexuality, use of term, 352, 353. *See also* Lesbian, gay, bisexual, and transgender (LGBT)

Homosexuality: A Psychoanalytic Study (Bieber 1962), 354

Honduras, 193, 194

Hong Kong, 131

“Honor killings,” and gender-based violence, 318

HOPE (mnemonic), 415, 416

Hopkins Symptom Checklist-25, 29

Hopkins Symptom Checklist-90 (SCL-90), 238

Hormone therapy, and transgender care, 397, 398, 401, 406

Hostility, and therapeutic relationship, 26

Hwa byung, 61, 142, 523

Hysteria, 288, 289

ICD-10, and homosexuality, 356. *See also* International Classification of Diseases ICD-9-CM V and ICD-10-CM Z codes

Identity. *See also* Cultural identity; Ethnic identity; Gender identity as distinct from identification, 12 use of term *identity label*, 359

Imipramine, 438

Immigration. *See also* Undocumented status

- Asian Americans and, 128, 130–133
Hispanic Americans and, 187–188, 189–193
history of and assessment of cultural identity, 14, 15, 54
supplementary module of Cultural Formulation Interview and, 514–516
In a Different Voice (Gilligan 1982), 316
India, and Indian Americans
 culture-bound syndromes in, 61, 142, 521, 529
 hijira and concepts of gender, 397
 immigration to U.S. and, 131
 population of immigrants to U.S., 129
 religion and, 136
Indian Child Welfare Act (1978), 257
Indian Health Service (IHS), 258–259
Indians, use of term, 253. *See also* Native Americans
Indinavir, 447, 458, 456
Indisposition, as culture-bound syndrome, 520
Indonesia, 142
Infant mortality, and African Americans, 82, 83
Informed consent, and transgender care, 401
Interethnic countertransference, 26
Interethnic transference, 26, 69
Intermediate metabolizers (IMs), 448
Internalization, of racism by African Americans, 97–98
Internalized homophobia, 362–363, 386
International Classification of Diseases ICD-9-CM V and ICD-10-CM Z codes, 61. *See also* ICD-10
Internet. *See also* Web sites
 bullying of sexual minorities and, 374
 references on ethnopsychopharmacology and, 457
 as source of information on lives of LGBT people, 370, 376
Internment camps, and Japanese Americans, 133
Interpersonal relationships. *See also* Marriage
 cultural issues for women and, 326
 gender issues in culturally competent assessment and, 297–300
Intraethnic transference, 69
Intrinsic orientation, of religion, 66
Inuit, and culture-bound syndromes, 65
Involutional paraphrenia, 63
Involvement, cultural identity and degree of, 14
Islam, 136, 422
Isolation, prevalence of in ethnic minority patients, 474
Italy, 526
It Gets Better Project (Internet), 374
Japan
 culture-bound syndromes in, 61, 142, 143, 529, 532–533
 menopause and, 320
Japanese Americans. *See also* Asian Americans
 ethnopsychopharmacology and, 442
 history of immigration to U.S., 132–133

- Japanese Americans (*continued*)
 population of, 129
 “Jim Crow” laws, 79
 “John Henryism,” and African Americans, 105–106
Joint Commission (Joint Commission on Accreditation of Healthcare Organizations), 341–342, 412, 562
Journals, on cultural psychiatry, 561
Judaism, 205, 324–325, 327, 549–552
- Kertbeny, Karl Maria, 352
Ketoconazole, 455
Khmer, 135
Khmu, 135, 136
Khyâl cap, 522–523
Kinsey, Alfred, 354
Kleinman, Arthur, 22, 23
Korea, and culture-bound syndromes, 61, 142, 523, 533
Korean Americans. *See also* Asian Americans
 community support and, 165
 ethnopsychopharmacology and, 441
 history of immigration to U.S., 132
 population of, 132
Koro, 61, 142, 521
Krafft-Ebing, Richard von, 352–353
Kufungisisa, 523–524
- Labeling, and Native Americans, 268
Lakota, 272
Language. *See also* Communication
 African Americans and, 108
 Asian Americans and, 127, 135, 136, 170
 cultural identity and, 48–49, 135
 Hispanic Americans and, 223–225
 Native Americans and, 255, 263
 telephone services for translation and, 45
 transgender patients and preferred names and pronouns, 403, 407
 translated editions of rating scales and, 29
 use of interpreters in assessment and, 30–34, 170
Laos, and Laotian Americans, 132, 135, 165, 523
Latab, 61, 142
Latin America
 culture-bound syndromes in, 62, 524
 origins of term, 198
Latino, use of term, 183–184, 198. *See also* Hispanic Americans
LEARN, as mnemonic for cultural formulation, 47, 74
Legal issues. *See also* Criminal justice system; Undocumented status
 gender issues in culturally competent assessment and, 301
 history of homosexuality and, 351–352
 same-sex marriage and, 356, 357–358
 stressors for Hispanic Americans and, 220
Lesbian, gay, bisexual, and transgender (LGBT). *See also* Sexual orientation; Transgender identity
 Asian Americans and, 153–154, 167
 common issues in mental health care for, 375–379
 cultural identity and, 359–375, 379–381
 disparities in mental health care for, 2

- epidemiology of, 343–346
health care needs of and experience
 with health care system, 340–342, 383
history of, 349–358
impact of religion and spiritual
 beliefs on, 418–419, 425
psychiatric disorders and suicide in,
 347–349
sexual identity terminology and,
 358–359
use of Outline for Cultural
 Formulation for, 379–388
use of term, 340
LGBT. *See* Lesbian, gay, bisexual, and
 transgender
Liaison Committee on Medical
 Education (LCME), 562–563
Life cycle
 developmental issues for women
 and, 307, 316–321
 development of sexual identity and,
 368–371
Life expectancy, of African Americans,
 82
Listening, and patient–clinician
 relationship, 107, 157–158
Locura, 62

Macho and *machismo*, 203, 236
Magical model, of cultural
 conceptualizations of distress, 21
Maladi moun, 525–526
Malaysia, and culture-bound
 syndromes, 61, 142
Mal de ojo, 63, 213, 526
Mal'occhiu, 526
Marginalization, of Asian American
 adolescents, 151
Marianas Islands, 133
Marianismo, 203–204
Marriage. *See also* Family; Interpersonal
 relationships
 gender issues in assessment and,
 313
 of LGBT people, 356, 357–358,
 377
Marshall Islands, 133
Matrifocal authority, in Hispanic
 American family, 202
Medicalization
 of homosexuality, 352–353
 of transgender identity, 397–398
Medical model, of cultural
 conceptualizations of distress, 22
Medical schools
 gender and students of or applicants
 to, 291
 nondiscriminatory policies
 including sexual orientation,
 342
Medicare, 457
Medicare Current Beneficiary Survey,
 88
Medicine men and medicine women,
 and Native Americans,
 273
Medicine wheel, and Native Americans,
 271
Mediterranean countries, and culture-
 bound syndromes, 63
Mediums espiritistas (spiritist mediums),
 212
Melanesians, and Pacific Islanders, 133
Menopause, 293, 320, 326
Menstruation, and gender issues in
 culturally competent assessment,
 293

- Mental health care. *See also* Help-seeking; Psychopharmacology; Stigma; Treatment; *specific disorders*
- African Americans and, 79–80, 83–92
- LGBT people and, 375–379
- Native Americans and, 258–259
- Mental Health: Culture, Race, and Ethnicity* (U.S. Department of Health and Mental Services 2001), 2, 279–280
- Mental status examination, and cultural assessment, 28–29
- Mestizos*, 194, 195, 197
- Metaphors, and communication with Asian American patients, 158, 163–164
- Mexican Americans. *See also* Hispanic Americans
- ethnopsychopharmacology and, 438, 449, 451
- history of, 187–188
- as percent of U.S. population, 185
- prevalence of psychiatric disorders in, 217–218
- Mexico
- culture-bound syndromes in, 62, 531
- Mexican Revolution and immigration to U.S., 188
- Microinsults and microaggressions, and African Americans, 93–94
- Micronesians, and Pacific Islanders, 133
- Middle Ages, and homosexuality, 350–351
- Mien, 135, 136
- Migration history. *See* Immigration; Refugees
- Military, and policy on homosexuality, 356
- Mind and body, spiritual belief in integration of, 140
- Mini-Mental Status Examination (MMSE), 29
- Misdiagnosis
- of Asian American patients, 171–172
- of depression in ethnic minorities, 437
- ethnic variation in
- psychopharmacology and, 436
- of Hispanic American patients, 235–237
- of schizophrenia in African Americans, 6, 85, 116–117
- Mistrust, in therapeutic relationship, 26
- Mnemonics
- spiritual assessment and, 52, 415, 416
- use of in cultural formulation, 47, 52, 53, 56–60, 66, 74
- Mohave, and culture-bound syndromes, 65
- Mongolia, 142
- Monitoring, and ethnopsychopharmacology, 461
- Mood stabilizers, and transgender patients, 407, 444
- Moral model, of cultural conceptualizations of distress, 21
- Moral objections to suicide (MOS), 414
- Mortality, and physical health status of African Americans, 83. *See also* Death
- Moxibustion, and traditional healing, 146, 148

- Nadelson, Carol, 303
- Napoleonic Code, and same-sex sexual behavior, 351
- Narrative, and incorporation of cultural factors into case formulation, 73
- National Comorbidity Survey, 85, 87, 218
- National Healthcare Disparities Report (Agency for Healthcare Research and Quality 2011), 88
- National Institute of Mental Health, 86, 452
- National Institutes of Health, 304
- National Survey of American Life, 84, 85, 89
- National Transgender Discrimination Survey Report on Health and Health Care, 402
- Native Americans
- concepts of gender and two-spirited people, 265, 397
 - cultural conceptualizations of distress and, 266–271, 524
 - cultural features of relationship between individual and clinician, 273–277, 278, 279
 - cultural identity of, 260–266
 - culture-bound syndromes and, 65, 267
 - geographic regions and cultural areas of, 254–255
 - heterogeneity of, 254
 - historical issues relating to mental health in, 255–258
 - lack of evidence-based practices for, 252
 - mental health needs of and service system issues, 258–259
 - overall cultural assessment of, 277–278
 - population of U.S. and, 2, 254
 - preparation of clinician for initial interview with, 259
 - psychosocial stressors and cultural features of vulnerability and resilience for, 271–273
 - sovereign nation status of tribal groups and, 255
 - use of OCF for, 260–280
- Naturalistic theory, and health beliefs of Asian Americans, 145–146, 148
- Navajo. *See* Diné
- N*-desmethyldiazepam, 442
- Nervios*, 209–211, 527. *See also* *Ataque de nervios*
- Neurasthenia, 142
- Neuroleptics, and
- ethnopsychopharmacology, 450, 460. *See also* Antipsychotics
- Nevra*, 527
- Nicaragua
- culture-bound syndromes in, 62
 - history of immigration to U.S. from, 193–194
- Nierbi*, 527
- Nifedipine, 456
- Nonadherence. *See* Adherence
- Nonverbal communication
- African Americans and, 109
 - Asian Americans and, 158
 - Hispanic Americans and, 225–227
 - Native Americans and, 266
- Normalizing statements, and LGBT patients, 380–381

- North Africa, and culture-bound syndromes, 64
- Nortriptyline, 438
- Nursing homes
- Hispanic Americans and, 202
 - LGBT people and, 378
- Nuyorican* identity, 197, 224
- Obama, Barack, 99
- Obeah (traditional healing), 100
- Obesity, rates of in African Americans, 86
- OCF. *See* Outline for Cultural Formulation
- Oedipal conflict, 353
- Olanzapine, 441, 442, 443, 452
- Older adults. *See* Elderly
- Olfactory reference syndrome, 532, 533
- Omniscient-omnipotent therapist, 26
- Orichas*, 205
- Our Bodies, Ourselves* (Boston Women's Health Book Collective 2011), 289
- Outline for Cultural Formulation (OCF). *See also* Cultural conceptualizations of distress; Cultural features of relationship between Individual and clinician; Cultural identity; Overall cultural assessment; Psychosocial stressors and cultural features of vulnerability and resilience
- African Americans and, 92–117
 - Asian Americans and, 134–174
 - development of, 8
 - in DSM-IV-TR compared to DSM-5, 8
 - ethnopsychopharmacology and, 460–461
 - framework for assessment in, 477–478
 - Hispanic Americans and, 196–240
 - as hypothesis-generating tool, 44
 - introduction to, 6–7
 - LGBT individuals and, 379–388
 - Native Americans and, 253, 260–280
 - overview of general themes of, 469–473
 - practical application of in clinical practice, 9, 11–14, 16–36
 - spiritual assessment and, 417–429
 - tips for application of in standard psychiatric evaluation, 44–46
 - transgender identity and, 405–408
 - women and, 321–331
- Overall cultural assessment
- African Americans and, 111, 114–117, 542
 - application of OCF to standard psychiatric evaluation and, 72–74
 - Asian Americans and, 171–174, 538–539, 545
 - cultural issues for women and, 329–331
 - Euro American patient and, 552
 - Hispanic Americans and, 233–239, 548–549
 - Native Americans and, 277–278
 - OCF framework for assessment and, 478
 - overview of in clinical practice, 34–36
 - overview of general themes of OCF and, 473
 - religion and spirituality in, 428–429
 - transgender patients and, 408

- Overcompliance, of patient, 26
- Overculturizing, and underculturizing, 184
- Overidentification, of clinician with patient, 27
- Pacific Islanders
 history of immigration to U.S., 133
 population of U.S. and, 2
 traditional beliefs about health and illness, 147
- Pakistan, 136, 521
- Palau, 133
- Palo mayombe*, 205
- Panama, 193, 194
- Panic attacks, 523
- Panic disorder, 519
- Parents and parenting. *See also*
 Children; Grandparents
 addendum of Cultural Formulation
 Interview for, 511–512
 LGBT people and, 369–370, 377
- Paroxetine, 439
- Patient-clinician relationship. *See*
 Countertransference; Cultural
 features of relationship between
 individual and clinician;
 Transference; Treatment
- Patient Health Questionnaire, 238
- Patrilineal authority, in Hispanic
 American family, 202
- Pen lom*, 523
- Perceptual alterations, as idioms of
 distress in Hispanic American
 groups, 212
- Personal appearance, and Asian
 Americans, 136. *See also* Clothing
- Personal history, gender issues in
 assessment of, 312–315
- Personalismo*, 232
- Person-centered care, and African
 Americans, 106, 118
- Peru, 195
- Philippines, and culture-bound
 syndromes, 142. *See also* Filipino
 Americans
- Physical contact, and nonverbal
 communication, 109, 159, 226
- Physical health status, of African
 Americans, 82–83
- Pibloktoq*, 65, 267
- Pierce, Chester, 93
- Pinching, and traditional medicine,
 146
- Pity, and therapeutic relationship, 26
- Place of origin, and cultural identity, 49
- Plants, and origins of substances of
 abuse, 457. *See also* Herbal
 medicine
- Plasma levels, ethnopsychopharmacol-
 ogy and monitoring of, 461
- Plato, 350
- Police. *See* Criminal justice system
- Political history, and assessment of
 psychosocial stressors, 24
- Polynesians, and Pacific Islanders, 133,
 397
- Poor metabolizers (PMs), 448, 449,
 453, 454
- Postpartum depression (PPD), 302,
 306, 320
- Posttraumatic stress disorder (PTSD)
 African Americans and, 85
 Asian Americans and, 164
 refugees from El Salvador and, 194
 religious or spiritual identity and,
 419
 susto and diagnosis of, 531

Poverty. *See also* Socioeconomic status

African Americans and, 81

Native Americans and, 271

PPD. *See* Postpartum depression

Practice Guidelines for the Psychiatric

Evaluation of Adults, 2nd Edition

(American Psychiatric

Association), 412

Pregnancy, and life cycles of women,

319–320

Prevalence. *See also* Epidemiology

of bisexuality, 367

of depression in African Americans,

84

gender differences in, 305–306

of homosexuality, 344–345

of suicidality in Asian Americans,

168

of transgender identity, 398–399

Prisons. *See* Criminal justice system

Problem-solving approach, to therapy

for Asian Americans, 161, 162

Protest Psychosis: How Schizophrenia

Became a Black Disease, The

(Metzl 2009), 117

Psychiatric Research Interview for

Substance and Mental Disorders

(PRISM), 238

Psychoanalytic psychotherapy,

161

Psychoanalytic theory, and

homosexuality, 353–354

Psychological approach, to treatment

for Asian Americans, 161–164

Psychological testing, and Hispanic

Americans, 237–238

Psychologization, and somatization in

Hispanic American groups, 211

Psychopharmacology. *See also*

Antidepressants; Antipsychotics;

Mood stabilizers; Selective

serotonin reuptake inhibitors

African Americans and, 89, 92, 438,

439, 441, 442, **443**, 449, 451,

452, 453, 460

Asian Americans and, 154–155,

156, 159, 165–166, 438, 439,

440, 441–442, **443**, 449, 451,

453, 454, 459–460

cultural formulation and choices of

medications, 73

cytochrome P450 enzymes and

environmental factors in, 454–

457

ethnic variation in medication

response and, 437–442

herbal medications and, 139, 455–

457, **458**, **459**

importance of nonpharmacological

factors in, 459–460

pharmacogenetics of drug-

metabolizing enzymes and,

165, **436**, 437, 442, **444**, 445,

446–447, 448–454

use of OCF for assessment of ethnic

variation in, 460–461

Psychosocial interventions, empirically

based for Hispanic Americans,

238–239

Psychosocial stress model, of cultural

conceptualizations of distress, 22

Psychosocial stressors and cultural

features of vulnerability and

resilience

African Americans and, 103–106,

541

- application of OCF to standard psychiatric evaluation and, 60–68
- Asian Americans and, 147, 149–154, 537–538, 544
- Cultural Formulation Interview and, 25, 219–220, 498–499
- cultural issues for women and, 326–327
- Euro American patient and, 551
- Hispanic Americans and, 217–222, 547–548
- LGBT people and, 370–371, 372
- Native Americans and, 271–273
- OCF framework for assessment and, 478
- overview of assessment of in clinical practice, 24–25
- religion or spirituality and, 66–67, 422–425
- summary of general themes of OCF and, 471–472
- transgender patients and, 406–407
- Psychotherapy. *See also* Cognitive-behavioral therapy; Family therapy; Group therapy; Psychoanalytic psychotherapy
- Asian Americans and, 155–156, 170
- cultural formulation and approaches to, 73
- transgender patients and, 407
- Psychotic disorders, and study of spirituality or religion, 420. *See also* Schizophrenia
- Puerto Rico
- culture-bound syndromes in, 62
- depression in immigrants from, 218
- migration of Hispanic Americans from, 189–190
- Qi-gong*, 61, 143, 171–172
- Race. *See also* Racism
- assessment of cultural identity and, 51
- Central America and concepts of, 194
- cultural identity of Hispanic Americans and perceptions of, 197–198
- definition of, 5–6
- disparities in mental health care and, 2
- psychosocial stressors and, 65–66
- South America and concepts of, 195
- suicide rates in sexual minorities and, 347
- use of mental health services by, 90–91
- Racism
- African Americans and, 78, 84, 85, 97–98, 106, 108
- Dominican Americans and, 192–193
- Rado, Sandor, 353–354
- Rating scales, and cultural issues in psychological assessment, 29
- Reaction formation, 353
- Reasons for Living Inventory, 414
- Refranes* (proverbs), 225, 239
- Refugees
- assessment of cultural identity and, 54
- Cuban Americans as, 191

Refugees (*continued*)

- Cultural Formulation Interview
 - and, 514–516
 - Vietnamese Americans as, 132
 - women as, 327
- Relational context, of development of sexual orientation for lesbians, 364–365
- Religion and spiritual beliefs. *See also*
- Buddhism; Catholicism;
 - Hinduism; Islam; Judaism
- African Americans and, 96–97, 100, 104, 107
- Asian Americans and, 136, 141, 143–145
- cultural conceptualizations of distress and help-seeking pathways, 421–422
- cultural identity and, 18, 52, 324–325, 327, 418–420
- diversity of in U.S., 411, 418
- FICA as screening tool for, 52
- Hispanic Americans and, 204–206, 208
- history of homosexuality and, 351
- importance of in medical patients, 412
- Native Americans and, 267–268
- overall cultural assessment and, 428–429
- patient-clinician relationship and, 425–428
- performing of spiritual assessment for, 413–417
- positive and negative effects of on mental health, 3
- psychosocial stressors and cultural features of vulnerability and resilience, 66–67, 422–425
- supplementary module of Cultural Formulation Interview on, 499–501
- use of OCF for spiritual assessment, 417–430
- “Religiosity gap,” between psychiatrists and general public, 427
- Religious Coping Index, 422–423
- Reparative therapy, 354
- Reservation system, and Native Americans, 256
- Respeto*, 232–233
- Retirement, and life cycles of women, 320–321
- Risk factors, for suicidality in Asian Americans, 168
- Risperidone, 441–442, 443
- Rites of passage, and gender issues in assessment, 312
- Role flexibility, in African American family, 103
- Role reversals, and Asian Americans, 151, 153
- Rootwork, as culture-bound syndrome, 64, 100, 102
- St. Elizabeth’s Hospital (Washington, D.C.), 80
- St. John’s wort, 450, 456–457, 458, 459
- Samoa, 133, 147
- Sanger, Margaret, 289
- Sanskrit, 136
- Santería*, 100, 205
- Sappho, 350
- Schizophrenia
 - African Americans and, 6, 85–86, 116–117
 - culturally informed therapy for, 238

-
- gender differences in, 306, 321
 - Segregation, and African Americans, 82
 - Selective serotonin reuptake inhibitors (SSRIs), 439, 453
 - Self-concept, and development of sexual identity, 368–369
 - Self-identification, and sexual orientation, 343, 358
 - Semistructured interview, Cultural Formulation Interview as, 479
 - Sensitization, and sexual identity, 362
 - September 11, 2001 (terrorist attacks), 422
 - Severity, of symptoms and distressing experiences, 57
 - Sex-selection practices, in reproduction, 319
 - Sexuality, interaction of with gender identity, 403
 - Sexual inversion, 353
 - Sexual orientation. *See also* Lesbian, gay, bisexual, and transgender (LGBT)
 - assessment of cultural identity and, 17–18, 50
 - dimensions of, 360, 361
 - disclosure of to providers, 343
 - gender issues in assessment and, 313
 - Native Americans and, 265
 - use of term, 359
 - Shamans and shamanism, 136, 146, 148, 273
 - Shenjing shuairuo*, 61, 528–529
 - Shen-k'uei*, 61, 521
 - Shin-byung*, 61
 - Shinkei-suijaku*, 61, 529
 - Shintoism, 136
 - Shona (Zimbabwe), 523
 - Sicily, 527
 - Silence, and Asian American patients, 158
 - Simpatia*, 232
 - Singapore, 521
 - Skin color, and African Americans, 96–98, 101
 - Slavery, African Americans and legacy of, 79, 108
 - Sleep paralysis, as culture-bound syndrome, 64
 - Social anxiety disorder, 532
 - Social approach, to treatment for Asian Americans, 165
 - Social distance, and Hispanic Americans, 226
 - Social phobia, 143
 - Social system. *See also* Community
 - influence of cultural formulation on treatment and, 73–74
 - stressors for Native Americans and, 271
 - supplementary module of Cultural Formulation Interview on, 497–498
 - support from as protective factor for Hispanic Americans, 221–222
 - supports for Native Americans and, 271–272
 - Society for the Study of Psychiatry and Culture, 563
 - Sociocentric stage, in development of sexual orientation, 364
 - Socioeconomic status. *See also* Poverty
 - of African Americans, 81–82, 85
 - of Asian Americans, 149

Socioeconomic status (*continued*)

- assessment of cultural identity and, 49–50

- gender issues in culturally competent assessment and, 292

- of Hispanic Americans, 185, 186, 187

Somatization and somatic complaints

- Asian Americans and, 140

- Hispanic Americans and, 211–212

South America

- culture-bound syndromes in, 531

- history of immigration from, 194–195

South Asian Americans. *See* IndiaSoutheast Asian Americans. *See also*

- Cambodia, and Cambodian

- Americans; Laos, and Laotian

- Americans; Vietnamese Americans

- countertransference and, 169

- cultural identity and preferred terms for, 135

- culture-bound syndromes and, 142, 325, 521, 524

- effects of trauma on children and adolescents, 151

- ethnopsychopharmacology and, 451

- gender issues for women and, 153

- history of immigration to U.S., 131–132

- migration history and potential trauma in, 14

- posttraumatic stress disorder in, 164

- Spain, 450, 526

- Spells, as culture-bound syndrome, 63, 102

- SPESial TEsT (mnemonic), 56

- SPIRIT (mnemonic), 415, 416

- Spiritual history, and Native Americans, 268

- Spirituality. *See* Religion and spiritual beliefs

- Spirituality in Patient Care: Why, How, When and What* (Koenig 2007), 412

- Spiritual/religious model, of cultural conceptualizations of distress, 21

- Sri Lanka, 523

- Srog rlung gi nad*, 523

- Staff members, as interpreters, 33

- Standards of Care, Version 7 (SOC 7), of WPATH, 400–402

Stereotypes

- of Asian Americans, 168–169

- of Hispanic Americans, 202–203, 227–228

- of Native Americans, 252

Stigma, of mental illness

- African Americans and, 88

- Asian Americans and, 156, 172–173

- Hispanic Americans and, 214

- history of homosexuality and, 352

- Native Americans and, 268

- Stonewall Riots (New York City 1969), 355

- Storytelling, and therapy for Hispanic American patients, 239

- Sub-Saharan Africa, and culture-bound syndromes, 64

Substance use disorders. *See also*

- Alcohol use and alcoholism

- African Americans and, 86, 88, 105

- Asian American adolescents and, 167

- ethnopsychopharmacology and, 457

- Hispanic Americans and, 218

-
- lesbian, gay, and bisexual people
 - and, 347, 348
 - Suicide and suicidal ideation
 - Asian Americans and, 168
 - assessment of religious and spiritual factors, 414–415
 - ataque de nervios* and, 520
 - gender differences in, 305, **310**
 - Hispanic Americans and, 220
 - lesbian, gay, and bisexual people and, 347–349, 374, 386
 - mental health status of African Americans and, 86
 - mental status examination and, **310**
 - Native Americans and, 258
 - transgender identity and, 402
 - Summary interpretations, 33
 - Support. *See* Psychosocial stressors and cultural features of vulnerability and resilience
 - Supreme Court, and civil rights, 79
 - “Survivor guilt,” and African Americans, 104
 - Susto*, **62**, 213, 530–531
 - Sweat lodges, and Native Americans, 271
 - Sweden, 450
 - Switzerland, 420
 - Symbiotic/ego-centric stage, in
 - development of sexual orientation, 364
 - Symonds, John Addington, 353
 - Symptoms, severity of and cultural norms of Native Americans, 268–269
 - Systems-oriented family therapy, for
 - Hispanic American patients, 238–239
 - Tabanka*, **64**
 - Tahiti, 133
 - Tai chi*, 145
 - Taijin kyofusho*, **61**, **143**, 532–533
 - Talking circles, and Native Americans, 271
 - Taoism, 136, **144**, 145
 - Tardive dyskinesia, and ethnopsychopharmacology, 460
 - Telephone translation services, 45
 - TEMAS (“Tell Me A Story”), 237–238
 - Thailand, 142
 - Thematic Apperception Test (TAT), 237–238
 - Therapeutic alliance, and Asian American patients, 162, 169
 - Therapeutic relationship. *See* Cultural features of relationship between individual and clinician
 - Therapeutic triad, and interpreters as team members, 30, **31**, 34
 - “Thinking too much,” as idiom of distress, 524
 - Tiananmen Square (June 1989), 130
 - Tibet, 523
 - Tiospaye*, and northern Plains Indian communities, 272
 - Tom Waddell Health Center (San Francisco), 401
 - Tonga, 133
 - Traditional healing. *See also* Herbal medicine
 - Asian Americans and, 139, 145–146, **148**, 171
 - Native Americans and, 270, 273–274

Transference

- Asian American patients and, 168–169
- cultural conflicts between clinician and patient, 25–26, 27
- interethnic and intraethnic issues in patient–clinician relationship and, 69
- women and, 328

Transgender identity. *See also* Lesbian, gay, bisexual, and transgender cultural conceptualizations of distress and, 406

cultural identity and, 405–406

formation of, 399–400

health care settings and, 402–405

medicalization of, 397–398

overall cultural assessment and, 408

patient–clinician relationship and, 407–408

prevalence of, 398–399

psychosocial stressors and cultural features of vulnerability and resilience for, 406–407

use of OCF and, 405–408

WPATH Standards of Care, Version 7 (SOC 7), 400–402

TRANSLATE, as mnemonic for cultural formulation, 47

Trauma. *See also* Posttraumatic stress disorder

- bullying of sexual minorities and, 374
- cultural issues for women and, 327
- gender issues in culturally competent assessment and, 300, 314–315
- immigrants and refugees from Southeast Asia and, 14

Native Americans and

- multigenerational, 257–258
- transgender identity and, 402

Trauma and Recovery (Herman 1992), 289–290

Trazodone, 438

Treatment. *See also* Adherence; Help seeking; Psychopharmacology; Psychotherapy

African Americans and, 87–88, 92, 106, 118

Asian Americans and approaches to, 159, 161–164

implications of sexual minority identity for, 383, 385–387

influence of overall cultural assessment on, 73–74

Treatment history, and cultural concepts of distress, 58–59

“Triangle model,” for role of interpreters in therapy, 170

Tribes, and cultural identity of Native Americans, 260–261, 262

Tricyclic antidepressants (TCAs), 139, 438, 449

Trinidad, and culture-bound syndromes, 64

Trust, in therapeutic relationship, 277

Two-spirited, and Native American concepts of gender, 265, 397

Ulrichs, Karl Heinrich, 352

Ultrarapid metabolizers (UMs), 448, 450

Ultrasound technologies, and gender issues, 319

Underculturalizing, and overculturalizing, 184

- Undocumented status, of immigrants, 53–54, 188, 192, 195
- United Kingdom, and study of religious beliefs in individuals with HIV, 425
- United States. *See also* California; Hawaii
- culture-bound syndromes in, 63
 - diversity of religious faiths in, 411, 418
 - Hispanic Americans as percentage of population, 184–185
 - increase in ethnic diversity of, 1–2, 127
 - political status of Puerto Rico and, 189
- U.S. Department of Health and Human Services, 563–564
- U.S. Department of the Interior, 133
- U.S. Department of State, 70
- Universalistic stage, in development of sexual orientation, 364
- Uqamairineq*, 65
- Values, of Asian Americans, 137
- Vata*, 523
- Venezuela, 195
- Venlafaxine, 448
- Verbatim translation, by interpreters, 31, 33
- Vietnamese Americans. *See also* Southeast Asian Americans
- case example of cultural formulation and, 535–539
 - community support organizations and, 165
 - history of immigration to U.S., 131–132
 - population of in U.S., 129
- Voodoo, 100
- Voting Rights Act (1965), 79
- War Bride Acts (1945), 130
- Web sites. *See also* Internet
- for sources of cultural information, 70
 - for suggested resources on cultural psychiatry, 561–564
 - for telephone translation services, 45
- Weight gain, and side effects of psychopharmacology, 442
- Wellness spirituality, 425
- West Africa, and culture-bound syndromes, 64
- West Indies, and culture-bound syndromes, 520. *See also* Caribbean
- Westphal, Karl, 352
- Where There Is No Psychiatrist* (Patel 2003), 303
- Wicinko*, 267
- Windigo*, 65, 267
- Winnebago. *See* HoChunk
- Women. *See also* Gender
- African American family and, 103–104
 - Asian Americans and, 152–153
 - clinical assessment of, 306–307
 - cultural conceptualizations of distress and, 325–326
 - Cultural Formulation Interview and, 331–332
 - cultural identity and, 323–325
 - deficiencies in mental health research and, 2
 - developmental issues in life cycles of, 307, 316–321

Women (*continued*)

- epidemiology and psychopathology in, 305–306
- history of women's movement and mental health issues, 288–291, 303–304
- marianismo* and Hispanic American, 203
- overall cultural assessment and, 329–331
- patient-clinician relationship and, 328–329
- psychosocial stressors and cultural features of vulnerability and resilience for, 326–327
- religion and African American, 422, 424
- use of OCF for, 321–331
- use of term *evil* by African Americans and, 101
- Workplace, and disclosure of sexual orientation, 377
- World Association of Cultural Psychiatry, 564

- World Health Organization, 356
- World Mental Health Surveys, 305
- World Professional Association for Transgender Health (WPATH), 399, 400–402
- World Psychiatric Association, Transcultural Psychiatry Section, 564
- World War II, and Japanese Americans, 133
- WPATH. *See* World Professional Association for Transgender Health
- Xenobiotics, 457
- Yin-yang* theory, 146
- Zaar*, 64
- Zen Buddhism, 136, 163–164. *See also* Buddhism
- Zimbabwe, 523